

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00963

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 52 Takoma Park			
c. LENGTH OF STAY IN lb 18 years				d. STREET ADDRESS 503 - Belford Place			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 503 Belford Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Besse June Ashley				4. DATE OF DEATH January 31 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 8 1879	
9. AGE (in years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Minnesota				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Emerick				14. MOTHER'S MAIDEN NAME Caroline Lowry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs Mabel A. Hauser, Prince Georges				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Debility 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectum (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb 4 1961			
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Mausoleum				22d. LOCATION (City, town, or country) (State) Minneapolis Minnesota			
23. FUNERAL DIRECTOR Arthur Walters				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
ADDRESS 254 Carroll St NW DC				DATE FEB 2 '61			

MEDICAL CERTIFICATION

2

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
1910

DEATH

1

MEDICAL CERTIFICATION

972

00964

1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c. LENGTH OF STAY IN 1b		22hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		66		Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Prince George's General Hosp.		d. STREET ADDRESS		6101 Norman Avenue		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
		Baby		Girl		Baldwin		1		12		19		61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		January 1, 1961		22		Hours		55		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
None				Maryland		U. S. A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Joseph Timothy Baldwin		Mary Concepcion McKnew													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
(If yes, give war or dates of service)		None		Mother		Same									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		762.5		DUE TO		Cerebral aneurysm		P. rem. aturty		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
January 11, 1961		January 12, 1961		January 11, 1961		4:15am									
21. I certify that (I) (this hospital) attended the deceased from January 11, 1961, to January 12, 1961, that (I) (we) last saw the deceased alive on January 11, 1961 and that death occurred at 4:15am the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		1-12-61									
Stanley H. Steinberg		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS		8106 New Hampshire Ave. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		Burial		Jan 13, 1961		Ft Lincoln Cemetery		Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		F Gasch's Sons		Hyattsville Md.		JAN 16 '61		Anthony S. Thomas	

2077329 XV

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

973

CERTIFICATE OF DEATH

Reg. Dist. No. 00965

1. PLACE OF DEATH a. COUNTY Prince George Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Prince Laurel Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 01 Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 1518 Main St	
3. NAME OF DECEASED (Type or print) Baldwin, Wm First Middle Last		4. DATE OF DEATH January 24 1961 Month Day Year	
5. SEX M 6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 25 1882 9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Government Printing Wash DC	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T. M. Baldwin		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel C. Baldwin		Address 1518 Main St Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphatic Leukemia DUE TO (c) Diabetes mellitus, Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-24 1961, to 1-24 1961, that I last saw the deceased alive on 1-24 1961, and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE IDOLO PIERANDREI M.D.			
PHYSICIAN'S NAME (Type) IDOLO PIERANDREI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61	
22c. NAME OF CEMETERY OR CREMATORY Ingle Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE FEB 1 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

768

66266

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, state RURAL and give nearest town) <u>Hillside</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Hillside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1107-57th Ave.</u>				d. STREET ADDRESS <u>1107-57th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>CATHERINE</u> Last <u>BELECHER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1902</u>	9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry O'Callaghan</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HINKELBINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-22-0222</u>		17. INFORMANT <u>MRS SHARTZER-1107-57th Ave Hillside W.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>with Generalized Metastases</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1959</u> , to <u>January 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 24, 1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Brainin</u>				22b. DATE SIGNED <u>1/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				22d. ADDRESS <u>6124 Central Ave Capitol Heights Md.</u>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/28/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u> ADDRESS <u>C-517-1195 SE. Washington</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00967

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>T. B.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hobson Clinic</u>				d. STREET ADDRESS <u>P.O. Box 116</u>			
3. NAME OF DECEASED (Type or print) <u>Lloyd Kenneth Bell</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 27, 1960</u>	
9. AGE (in years last birthday) <u>3 yrs.</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>James Leroy Bell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Deloris Jean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Mary D. Bell</u> Address <u>same as # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Pneumonia, Broncho</u> 491X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>1-21-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST Peters</u>		22d. LOCATION (City, town, or country) (State) <u>WALDORF MD</u>	
23. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>				24. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

VS. A15ME
5M 7/59

2077286XVV

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
1900

100-100000
100-100000

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100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00968

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b LANDOVER HILLS			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER HILLS d. STREET ADDRESS 4212 70th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRED Middle BEINOIT Last BEINOIT			4. DATE OF DEATH Month JANUARY Day 23 Year 19 61		
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 July 1908		9. AGE (In years lost birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES			13. FATHER'S NAME WILLIAM BEINOIT		
14. MOTHER'S MAIDEN NAME LAURA BEINOIT HARRELL			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1931-1959		
16. SOCIAL SECURITY NO. 006-01-3866			17. INFORMANT WIFE (MRS FRANCES BEINOIT) SAME AS ITEM #2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromboses of Abdominal Aorta and Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 454X DUE TO Uncertain Cause DUE TO Uncertain Cause INTERVAL BETWEEN ONSET AND DEATH 3 weeks unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from 3 Jan 1961 to 23 Jan 1961 that (I) (last saw the deceased alive on 23 Jan 1961 and that death occurred at 12:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Moon		22b. DATE SIGNED 23 Jan 61		22c. PHYSICIAN'S NAME (Type) CHARLES S MOON, CAPT USAF (MC)	
22d. ADDRESS USAF HOSP, ANDREWS AFB, WASH 25 DC		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.27.1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town, or county) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300.4th st N E.Wash.			
25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. K...			

CERTIFICATE OF DEATH

Reg. Dist. No.

976

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS. 19	
d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION SOUTHERN MARYLAND HOSPITAL CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle HARMER Last BISSETT		4. DATE OF DEATH Month JANUARY Day 8 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 62 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FREDERICK A HARMER		14. MOTHER'S MAIDEN NAME LILLIAN H. WARNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-6431	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) CORONARY ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOVEMBER 9, 1961 to JANUARY 8, 1961 , that I last saw the deceased alive on JANUARY 8th , 1961, and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David N. Robb		ADDRESS (Street, city or town, state) 5116 Middleton Lane	
PHYSICIAN'S NAME (Type) DAVID N. ROBB		DATE SIGNED Washington 22 D.C. (Camp Springs Md)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-10-61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Chittenden, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers + Co		24a. REC'D BY REGISTRAR 517-17th ST	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna		DATE JAN 12 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
977
CERTIFICATE OF DEATH

00970

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Garrett</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bellefonte, Md</i>		c. LENGTH OF STAY IN 1b <i>---</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1221 Dorset Lane</i>		d. STREET ADDRESS <i>11X-1</i>	
3. NAME OF DECEASED (Type or print) First <i>RAYMOND</i> Middle <i>E</i> Last <i>BITTINGER</i>		4. DATE OF DEATH Month <i>JAN</i> Day <i>14</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1889</i> <i>June 17, 1888</i>
9. Age (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter-Cabinet Maker, Self Empl.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Perry Bittinger</i>		14. MOTHER'S MAIDEN NAME <i>Martha Ellen Speicher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-01-8319</i>	
17. INFORMANT <i>Delbert Bittinger</i>		Address <i>Mt. Lake Park, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerotic Heart Dis</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>30</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-5</i> to <i>1-14</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>1-14</i> , 19 <i>61</i> , and that death occurred at <i>1:30</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.C. Etienne</i>		22b. DATE SIGNED <i>1-14-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.C. ETIENNE</i>		22d. ADDRESS <i>College Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/17/1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Oakland Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Oakland, Maryland.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leighton Funeral Home</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 19 '61</i>	
ADDRESS <i>Oakland, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Harris</i>	

Leighton Funeral Home Oakland, Md.

STT

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978

CERTIFICATE OF DEATH

00971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier,				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3711 Perry Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR RAY First Middle Last Bollinger				4. DATE OF DEATH JAN 30 1961 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1890	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Sanitary Commission		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William H. Bollinger				14. MOTHER'S MAIDEN NAME Stella Harbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Mrs. Nora R. Bollinger Same as #2 (Wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 2 yrs CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 12/4 , 19 58 , to 1/30 , 19 61 , that I last saw the deceased alive on 1/30 , 19 61 , and that death occurred at 12:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Cramer M.D.				ADDRESS (Street, city or town, state) 3503 Perry St Mt Rainier Md. DATE SIGNED 1/30/61			
PHYSICIAN'S NAME (Type) Norman Donat Cramer				22. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE FEB 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Prison Chaplain

Maryland

15 years

Still living

Age 75

Age 75

Maryland

Still living

Age 75

Age 75

Maryland

Still living

Age 75

Age 75

Maryland

Still living

Age 75

Age 75

Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00972

979

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>10</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A wooded area</u>				e. STREET ADDRESS <u>Letcher's Road and R381</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl</u> First <u>Edith</u> Middle <u>Booth</u> Last				4. DATE OF DEATH <u>January</u> Month <u>5</u> Day <u>1961</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1928</u>	
9. AGE (In years last birthday) <u>32</u> Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Joseph Louis Booth, Seniors #2</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound of head</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self in the head with a 38 Cal Revolver</u>					
20c. TIME OF INJURY Month, Day, Year <u>1-5-61</u> Hour <u>1-5</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wooded area</u>		20f. (City or town) <u>Brandywine P.G. Co.</u> (County) <u></u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-5-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) <u>Waldorf MD.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
980
CERTIFICATE OF DEATH
00973

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				d. STREET ADDRESS <u>16212 NOTTINGHAM DR. (WASH DC)</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW</u> <u>MI</u> <u>BOTTARI</u>				4. DATE OF DEATH Month Day Year <u>JAN</u> <u>10</u> <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 2, 1889</u>			
9. AGE (In years last birthday) yrs. <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - BUSSMAN</u>		11. BIRTHPLACE (State or foreign country) <u>ASTO, ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CAESAR BOTTARI</u>				14. MOTHER'S MAIDEN NAME <u>GIOVANNA MARTELLA</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>056-07-5043</u>					
17. INFORMANT <u>SON-IN-LAW - 6212 NOTTINGHAM DRIVE WASHINGTON DC</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Radio Respiratory Failure</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Metastatic Carcinoma - Sigmoid (Stom 3+ mo.</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (H) (this hospital) attended the deceased from <u>19 Dec</u> 19 <u>60</u> to <u>10 Jan</u> 19 <u>61</u> that (H) (we) last saw the deceased alive on <u>10 Jan</u> 19 <u>61</u> , and that death occurred at <u>12 M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Charles B Mahon</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10 Jan 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>CHARLES B MAHON</u>				22d. ADDRESS <u>USAF HOSPITAL ANDREWS, AAFB, WASH 25, DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 13 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Raymonds Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brooklyn N.Y.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>				25a. REC'D BY REGISTRAR <u>3225 HIGH ST.</u>		25b. REGISTRAR'S SIGNATURE <u>Christina S. Hanna</u>			
ADDRESS <u>13 BALTIMORE MD.</u>				DATE <u>JAN 12 '61</u>					

080

CERTIFICATE OF DEATH

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FOR THE T. W. L. D. C.

WASHINGTON NATIONAL

WASHINGTON, D. C.

1 FEB 21

URGENT

982

CERTIFICATE OF DEATH

Reg. Dist. No.

00975

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		c. LENGTH OF STAY IN 1b 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR				d. STREET ADDRESS 1207 Quincy St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle R Last BREEN				4. DATE OF DEATH Month JANUARY Day 12, Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1868	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk		10b. KIND OF BUSINESS OR INDUSTRY Kann's Dept. Str.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Breen				14. MOTHER'S MAIDEN NAME Bridget Crowley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Mary Davis Crouch #2d above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO (b) Coronary occlusion DUE TO (c) Gen Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Semi- Yes <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1961, to Jan 12, 1961, that I last saw the deceased alive on Jan 6, 1961, and that death occurred at 11:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5601 - 421 NW Wash DC DATE SIGNED							
ACTUAL SIGNATURE F. X. COURTNEY M.D.		PHYSICIAN'S NAME (Type) F. X. COURTNEY M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 Jan 1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, Inc. 317 Pa. Ave., SE				24a. REC'D BY REGISTRAR JAN 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN SENATE,
January 11, 1911.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1909.

ALBANY:
J. B. LEECH, STATE PRINTER,
1911.

CERTIFICATE OF DEATH

Reg. Dist. No.

00976

983

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 2414 Valleyway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary		First Ann		Middle Brown		Last	
4. DATE OF DEATH Jan 11,		Month		Day		Year 19 61	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 8, 1890	
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Long				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 38 3771		INFORMANT Raymond E Brown		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, arterial sclerosis DUE TO (c) heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-3 , 19 42 to 7-11 , 19 61 that I last saw the deceased alive on 7-9-61 , 19 61 , and that death occurred at 11:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John P Clum		M.D. Hyattsville Md.		ADDRESS (Street, city or town, state) Hyattsville, Md.		DATE SIGNED 1/13/61	
PHYSICIAN'S NAME (Type) John P Clum							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 14, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REG'D BY REGISTRAR JAN 16 61	
				DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE DEPT. OF

Prince George's
University, Md.
Prince George's General Hospital
and
Mary
Brown
Jan 11, 1961
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64-1-1-1960
U.S.A.
Missouri
own home
nonresidential
George Jones
Unknown
215 28 571 Raymond B. Brown, University, Md.

1/11/61

University, Md.

John I. Jones

Jan 11, 1961 12:00 PM

George's home - University, Md.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

984

Item 7, Piling 2-28-61 et

00977

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 Day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 7263 L St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Pearl Middle Last Brown			4. DATE OF DEATH Month Jan. Day 25 Year 61		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1887		9. AGE (In years last birthday) yrs. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Starling Jackson			14. MOTHER'S MAIDEN NAME Malinda Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Nettie E. Davis Address 7263-L St. (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-0 Anteroselectic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Malnutrition (c) Severe Dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 24, 1961 to Jan. 24, 1961 , that (I) (we) last saw the deceased alive on Jan. 25, 1961 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Gordon W. Kelley		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) 6124-41st Ave. Hyattsville, Md	
22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-30-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.	
23d. LOCATION (City, town, or county) Suitland Md		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington		ADDRESS 4925 Pease Ave NE		25a. REC'D BY REGISTRAR JAN 30 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Krasner					



RECEIVED AT DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250
JAN 10 1961

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Mr. Tolson
and Mr. Boardman

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CERTIFICATE OF DEATH

Reg. Dist. No.

00978

985

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X District Heights			
c. LENGTH OF STAY IN 1b 13 years				d. STREET ADDRESS 7406 Harwood Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7406 Harwood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSA ANN BROWN				4. DATE OF DEATH Month JAN. Day 27 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27th, 1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 27 Days 19 Hours 61 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Josiah Edyburn				14. MOTHER'S MAIDEN NAME Mary Ann Sharp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daisy W. Cole, 7406 Harwood Rd. District Hgts., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease (c) Generalized debility							INTERVAL BETWEEN ONSET AND DEATH 16 days 3 mos Long standing
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized debility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-26, 1960 , to 1-27, 1961 , that I last saw the deceased alive on 1-11, 1961 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.B. Sheer		ADDRESS (Street, city or town, state) DATE SIGNED 7200 MARLBORO PIKE 1-27-61					
PHYSICIAN'S NAME (Type) WALTER B. SHEER		WASH. 28, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/1961		22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Muskogee, Okla.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Wash. DC				ADDRESS 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE JAN 31 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

986

CERTIFICATE OF DEATH

00979

Item 14 Film 5279 1-30-61 et

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence H Burgess		4. DATE OF DEATH Jan 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1900
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY CITY OF CHEVERLY, MD	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLARENCE H. BURGESS		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1-14-1961	
17. INFORMANT MRS BARBARA J. COULTER		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Occlusion of left coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Arteriosclerotic H.T. Disease DUE TO Coronary Arteriosclerotic H.T. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14-1961 to 1-21-1961 that (I) (we) last saw the deceased alive on 1-21-1961 , and that death occurred at 8:25A from the causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED 1-23-61	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth M.D.		22d. ADDRESS 5510 Madison St., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN-26-61	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town, or county) (State) BLADENSBURG, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Riverdale Md		25. REC'D BY REGISTRAR JAN 26 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles E. Riverdale	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
OFFICE OF THE ASSISTANT SECRETARY

REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1900

THE
DEPARTMENT OF HEALTH
HAS THE HONOR TO
ACKNOWLEDGE THE RECEIPT
OF THE REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1900

AND TO
REPLY TO THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1900

IN THE
MONTH OF
JANUARY, 1901

CERTIFICATE OF DEATH

Reg. Dist. No.

00981

987

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAPHILL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAPHILL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8700 LIVINGSTON RD.			
3. NAME OF DECEASED (Type or print) EVELYN BUTLER				4. DATE OF DEATH Month 1. Day 25. Year 1961			
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7.13.09		9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM NEWMAN				14. MOTHER'S MAIDEN NAME ANNIE SAMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM E. BUTLER		Address (SEE # 2 B)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEIOSCLEROSIS, GENERAL DUE TO (c) HYPERTENSIVE CARDIAC DISEASE						INTERVAL BETWEEN ONSET AND DEATH 12 yrs. 6 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1, ANEURYSM OF ASCENDING AORTA, 2, AORTIC INSUFFICIENCY						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1956 , to January 25, 1961 , that I last saw the deceased alive on January 25, 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED PAUL CHEN, M. D. ACCOKEEK, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 1.30.61		22c. NAME OF CEMETERY OR CREMATORY SHILOH A.M.E. MET. CH.		22d. LOCATION (City, town, or county) (State) NEWBURG, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. McE...				ADDRESS 1820 9TH, N.W.		24a. REC'D BY REGISTRAR JAN 27 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. K...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00980

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Prince Georges County</div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">6013 St. Barnabas Oxen Hill</div> c. LENGTH OF STAY IN 1b <div style="text-align: center; font-weight: bold; font-size: 1.2em;">6013 St. Barnabas Road</div> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Maryland</div> b. COUNTY <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Prince Georges</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Oxen Hill</div> d. STREET ADDRESS <div style="text-align: center; font-weight: bold; font-size: 1.2em;">6013 St. Barnabas Road</div>			
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-weight: bold; font-size: 1.2em;"> THEODORE JOHN MELZIE JOHN BUTLER </div>				4. DATE OF DEATH Month Day Year <div style="text-align: center; font-weight: bold; font-size: 1.2em;">January 7, 1961</div>			
5. SEX <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Male</div>		6. COLOR OR RACE <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Negro</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <div style="text-align: center; font-weight: bold; font-size: 1.2em;">3 - 4 - 1912</div>		9. AGE (In years last birthday) yrs. <div style="text-align: center; font-weight: bold; font-size: 1.2em;">48</div>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Laborer</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-weight: bold; font-size: 1.2em;">General</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Maryland, Waldorf</div>			
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-weight: bold; font-size: 1.2em;">U.S.A</div>							
13. FATHER'S NAME <div style="text-align: center; font-weight: bold; font-size: 1.2em;">John Butler</div>				14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Georgianna Brown</div>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Unknown</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Unknown</div>		17. INFORMANT Mary C. Butler Address 249 Warren St. N.E., Prince Geo County Police Dept Wash DC.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-weight: bold; font-size: 1.2em;">Hemorrhage and Shock</div> (b) <div style="font-weight: bold; font-size: 1.2em;">Gumshot wound right shoulder and chest.</div> (c) </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Shot during an altercation in his home</div>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="font-weight: bold; font-size: 1.2em;">1/7/ 1961</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Home</div>			
20f. (City or town) (County) (State) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Oxen Hill Prince Georges Cty.</div>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <div style="font-weight: bold; font-size: 1.2em;">James I. Boyd</div>		EXAMINER'S NAME (Type) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">JAMES I. BOYD, M.D.</div>		DATE SIGNED <div style="text-align: center; font-weight: bold; font-size: 1.2em;">January 7, 1961</div>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Burial</div>		22b. DATE THEREOF <div style="text-align: center; font-weight: bold; font-size: 1.2em;">1-14-61</div>		22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Zion Wesley</div>			
22d. LOCATION (City, town, or country) (State) <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Waldorf, Maryland</div>							
23. FUNERAL DIRECTOR <div style="text-align: center; font-weight: bold; font-size: 1.2em;">THE HUNTT FUNERAL HOME, WALDORF, MARYLAND.</div>		24a. REC'D BY REGISTRAR <div style="text-align: center; font-weight: bold; font-size: 1.2em;">JAN 16 '61</div>		24b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Arthur S. Kraus</div>			

FOR STATE
HEALTH DEPT.

James George Jones
Oxley Hill
Oxley Hill
Oxley Hill

James George Jones
Oxley Hill
Oxley Hill
Oxley Hill

James George Jones
Oxley Hill
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389

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60982

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 Hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl				4. DATE OF DEATH Jan 17 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1961	
9. AGE (187 years last birthday) yrs. Jan		10. IF UNDER 1 YEAR Months 17		11. IF UNDER 24 HRS. Days 3		12. IF UNDER 24 HRS. Hours 20 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Raymond Ignatius Cannon				14. MOTHER'S MAIDEN NAME Elizabeth Ann Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mother				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Long atelectasis 782.5 DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Immature birth 790-001 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 790-001							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 16 1961 to Jan 17 1961 , that (I) (we) last saw the deceased alive on 19 61 , and that death occurred at 8:45A from the causes and on the date stated above.							
22a. SIGNATURE C. GEORGE HARDY				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) C. GEORGE HARDY				22d. ADDRESS 6827 ANNAPOLIS Rd. LANDOVER HILLS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/18/61			
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City, town, or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REGISTRAR JAN 20 '61			
ADDRESS Hyattsville, Md.				25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

2077384XV1

CERTIFICATE OF DEATH

299

Washington, D.C.

Mc. Oliver Cemetery

1/18/01

Partial

March's Bone Hospital, No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

990

CERTIFICATE OF DEATH

Reg. Dist. No.

00983

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL				d. STREET ADDRESS 604 63rd Pl.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CASSIUS First E. Middle CARRICK Last				4. DATE OF DEATH JAN. Month 15 Day 1961 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 16 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY D.C. SCHOOL EMP.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William E. Carrick				14. MOTHER'S MAIDEN NAME Mary F. Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579010402			
17. INFORMANT FRANCES R. CARRICK SAME AS # 2 (wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) PULMONARY CONGESTION DUE TO ARTERIO SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO ARTERIO SCLEROTIC HEART DISEASE (c) ARTERIO SCLEROTIC HEART DISEASE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal Peptic Ulcer & Hemorrhage							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN. 11 61 , 19____, to JAN. 15 , 19 61 , that I last saw the deceased alive on JAN 15 , 19 61 , and that death occurred at 2:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4500 COLLEGE AVE. COLLEGE PK, Md. DATE SIGNED 1/15/61							
ACTUAL SIGNATURE Wm. A. Holbrook, M.D.				PHYSICIAN'S NAME (Type) Wm. A. Holbrook, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) X BURIAL				22b. DATE THEREOF 1/17/61		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	
22d. LOCATION (City, town, or county) (State) XXM Suitland Md.							
23. FUNERAL HOME'S SIGNATURE F. Gasch's Sons				ADDRESS 4737 BALTIMORE AVE. HWY. 11		24a. REC'D BY REGISTRAR JAN 19 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

280

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
SEX
AGE
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF BURIAL

DATE OF DEATH
PLACE OF DEATH
SEX
AGE
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF BURIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

66984

991

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Londover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Londover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Box 123, Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>Gwendolyn</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 Oct. 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John R. Young</u>				14. MOTHER'S MAIDEN NAME <u>Sarah F. Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>James O.P. Carter, Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke-Cerebro-Vascular</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis, Generalized</u> DUE TO (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Jan 2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2 Jan</u> , 19 <u>61</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thos M. Hutchins</u> M.D. <u>7315 Londover Rd</u> PHYSICIAN'S NAME (Type) <u>Thomas M. Hutchins</u> <u>Hyattsville, Maryland - 2/4/1961</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

992

CERTIFICATE OF DEATH

00985

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale MD</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale MD</u> d. STREET ADDRESS <u>1st and Auburn Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Cartmell</u> Last <u>Cartmell</u>		4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877</u> <u>2-12-11877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cartmell</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-9557</u>	
17. INFORMANT <u>Hospital Records, Riverdale MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles House</u>		22b. DATE SIGNED <u>1-25-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles House</u>		22d. ADDRESS <u>15541 Columbia Road Burtonsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 27, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Dasch's Sons</u>		25a. REC'D BY REGISTRAR <u>Hyattsville Maryland.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>		DATE <u>Jan 27 '61</u>	

MAY 16 1970

100

4250

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

993

00986

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp</u>				d. STREET ADDRESS <u>R 7 D - Bx 282</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herbert</u> Last <u>Chalmers</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1961</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-20-81</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Chas. James Chalmers</u>				14. MOTHER'S MAIDEN NAME <u>House Simmeron</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Record</u> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE <u>Charles House</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-15-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles House</u>				22d. ADDRESS _____				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/18/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem. Baltimore MD.</u>		23d. LOCATION (City, town, or county) _____ (State) _____				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Truman Schwab</u>				ADDRESS _____		25a. REC'D BY REGISTRAR DATE <u>JAN 17 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

3512 Frederick Ave. (29)

CERTIFICATE OF DEATH

103

(M)

(1)



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
994 CERTIFICATE OF DEATH

02194

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>3 hrs - 15 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HUNTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE'S GENERAL HOSP.</u>				d. STREET ADDRESS <u>N - STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>CHASE</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-61</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u>		11. IF UNDER 24 HRS. Hours <u>3</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Leon Chase</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DAKAS Harrod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Attention</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 12</u> 19 <u>61</u> to <u>Jan. 13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Jan. 12</u> 19 <u>61</u> , and that death occurred at <u>12AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John W. Penn</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HARRY W. PENN, ADM.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Jan. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp</u>		23d. LOCATION (City, town, or county) (State) <u>Cheverly, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY W. PENN, ADM.</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>FEB 21 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2077234XV3

CERTIFICATE OF DEATH

200

1. Name of deceased: *James M. Smith*
2. Sex: *Male*
3. Age: *65*
4. Date of death: *Jan 15 1924*
5. Place of death: *Home*
6. Cause of death: *Heart failure*
7. Signature of physician: *[Signature]*
8. Signature of registrar: *[Signature]*
9. Date of registration: *Jan 16 1924*
10. Place of registration: *City of New York*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MAYARD STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
995
CERTIFICATE OF DEATH
60987

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		d. STREET ADDRESS <u>18902 Baltimore Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Neal</u> First <u>J.</u> Middle <u>Chase</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>15</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-10</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Triangle Motors</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Chase</u>		14. MOTHER'S MAIDEN NAME <u>Maggie E Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>745-</u>	
17. INFORMANT <u>Sister in law</u>		Address <u>4901 Harford Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastrointestinal bleeding</u> <u>541.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Blinding duodenal ulcer</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1960</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> 19 <u>60</u> to <u>Jan 15</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 15</u> 19 <u>61</u> , and that death occurred at <u>12 M</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore Zegarra M.D.</u>		22b. DATE SIGNED <u>Jan 15, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Theodore Zegarra</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 18, 1961</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
25a. REC'D BY REGISTRAR <u>JAN 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1. Name of deceased: *James P. [illegible]*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Oct 10 1910*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Duration of illness: *Several days*
8. Name of attending physician: *Dr. [illegible]*
9. Name of medical examiner: *[illegible]*
10. Name of coroner: *[illegible]*

11. Name of informant: *[illegible]*
12. Address of informant: *[illegible]*
13. Signature of informant: *[illegible]*
14. Date of completion: *Oct 15 1910*
15. Name of registrar: *[illegible]*
16. Signature of registrar: *[illegible]*
17. Date of registration: *Oct 15 1910*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
996 CERTIFICATE OF DEATH

00988

1. PLACE OF DEATH a. COUNTY <u>PRINCE George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>46</u> MD. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>BRENTWOOD</u> b. COUNTY <u>PG</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46</u> MD. d. STREET ADDRESS <u>3822-37th Pl.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>M.</u> Middle <u>CLANCY</u> Last 4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1961</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>6-10-93</u> 9. AGE (In years lost birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min.			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (State or foreign country) <u>Washington DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Raymond T. Baur</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>3822-37th Pl. Brentwood, Md.</u> 17. INFORMANT <u>Robert J. Clancy, son</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Multiple Pulmonary Emboli</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Pulmonary Emboli</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>1-13</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>1-13</u> 19 <u>61</u> , to <u>1-26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gorden W. Kelley</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>GORDEN W. KELLEY</u> 22d. ADDRESS <u>6124-45th Ave. N. Myrtle Md</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 30/61</u> 23b. DATE THEREOF <u>Jan. 30/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kelley's Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier Md.</u> 25a. REC'D BY REGISTRAR <u>FEB 1 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>							

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2

History of Present Illness
The patient is a male, aged 45 years, who has been ill for the past 6 months. He complains of persistent cough, expectoration of sputum, and loss of weight. He has also experienced night sweats and occasional hemoptysis. The illness began insidiously, with a gradual increase in cough and sputum production. He has been unable to work for the past 3 months due to increasing weakness and fatigue. He has no known contact with anyone who has tuberculosis. He has no other medical history and is on no other medications.

Physical Examination
On admission, the patient appeared ill and was in moderate distress. He was afebrile, with a pulse rate of 90 beats per minute and a blood pressure of 110/70 mmHg. The respiratory system examination revealed hyperinflation of the lungs, with decreased breath sounds and increased crackles in the lower lung fields. The heart and abdominal examination were within normal limits.

Investigations
Chest X-ray: The chest X-ray showed bilateral hyperinflation of the lungs. There were bilateral infiltrates in the lower lung fields, with some consolidation in the right lower lobe. The heart size was within normal limits. The diaphragm was flattened, and there was a small amount of pleural effusion on the right side.

Laboratory Investigations: The sputum examination was positive for acid-fast bacilli (AFB) on Ziehl-Neelsen stain. The sputum culture was positive for Mycobacterium tuberculosis complex. The tuberculin skin test (TST) was positive, with an induration of 15 mm. The hemoglobin level was 10 g/dL, and the white blood cell count was 10,000/mm³.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

997
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

66989

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital		d. STREET ADDRESS Rose Mary Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lucy ELIZABETH WINSTON Clay		4. DATE OF DEATH Month Day Year Jan. 27 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ambrose W. Winston.		14. MOTHER'S MAIDEN NAME Hellia Lee Rucker.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Winston Clay 7200 Wells Parkway			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA + UREMIA 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophogeal Diverticulum IN NECK DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GANGRENE of heart due to blood poisoning treated successfully by surgery		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at 8:25 M, from the causes and on the date stated above.			
22a. SIGNATURE Wilkinson M.D.		22b. DATE SIGNED Jan 27, 1961	
22c. PHYSICIAN'S NAME (Type) R Wilkinson		22d. ADDRESS Leland Hospital Riverdale Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		23b. DATE THEREOF Jan 29, 1961	
23c. NAME OF CEMETERY OR CREMATORY Alta Vista		23d. LOCATION (City, town, or county) (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons		25a. REC'D BY REGISTRAR FEB 2 '61	
ADDRESS Hyattsville, Maryland.		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

907

Place of birth
Riverdale
Age at death
11 years, 11 months, 1 day
Sex
Male
Date of death
January 11, 1901
Place of death
Chicago, Ill.
Cause of death
Diphtheria

(1)

Signature of physician
J. H. [illegible]
Date of report
Jan 20, 1901
Place of report
Chicago, Ill.
Signature of registrar
[illegible]
Date of registration
Jan 20, 1901
Place of registration
Chicago, Ill.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
998 **CERTIFICATE OF DEATH** **66998**

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle C. Last Cook				4. DATE OF DEATH Month January Day 21 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-19-1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Henry B. Cook Co., Food Brokerage				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry B. Cook				14. MOTHER'S MAIDEN NAME Lulu Pfaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-07-9369		17. INFORMANT Address Daughter Mrs. Marjorie C. Howard N.J.			
18. CAUSE OF DEATH [Enter only one cause per the far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 584X IMMEDIATE CAUSE (a) Buried pneumonia and Pulmonary embolism DUE TO Cholangitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstruction of common bile duct by gallstones - surgically removed 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 10 19 61 to Jan. 21 19 61 that (I) (we) last saw the deceased alive on Jan. 21 19 61 and that death occurred on 5:50 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Aaron Deitz				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Aaron Deitz				22d. ADDRESS 4314 Gallatin St., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1/24/61		Ft. Lincoln Cemetery		Pr. Geo. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				25a. REC'D BY REGISTRAR JAN 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
999 **CERTIFICATE OF DEATH**

00991

1. PLACE OF DEATH a. COUNTY PRINCE George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND. b. COUNTY P.R.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILLUM 50			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6011 Riggs Road				d. STREET ADDRESS 6011 Riggs Road 1			
3. NAME OF DECEASED (Type or print) First ELLEN Middle COUMARIS Last COUMARIS				4. DATE OF DEATH Month JAN Day 17 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE	
12. CITIZEN OF WHAT COUNTRY? ALIEN U.S.A.							
13. FATHER'S NAME PETER BELITZOS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT LOUIS COUMARIS (SON)		Address 6011 Riggs Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 48 HOURS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15 19 57 to 1/17 19 61 , that (I) (we) lost saw the deceased alive on 1/17 19 61 , and that death occurred at 8:30 M, from the causes and on the date stated above.							
22a. SIGNATURE James C Mandes				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES C MANDES				22d. ADDRESS 1401 16th St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				25a. REC'D BY REGISTRAR DATE JAN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

100

Form 100 (1915)

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of birth: _____

7. Cause of death: _____

8. Signature of Registrar: _____

9. Signature of Physician: _____

10. Signature of Coroner: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1000

CERTIFICATE OF DEATH

Reg. Dist. No.

00992

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville c. LENGTH OF STAY IN 1b Hyattsville d. NAME OF HOSPITAL (If not in hospital, give street address) 6403 Ager Road (Mrs Bells N. H.)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 8506 Fremont St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Lewis Croft First Middle Last		4. DATE OF DEATH Jan 5 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1959 9. AGE (In years last birthday) 2 10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hal. Lewis Croft		14. MOTHER'S MAIDEN NAME Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hal L. Croft (Father)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute upper respiratory infection 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease DUE TO (c) Mongolism		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 5, 1960 to 1/5, 1961 , that I last saw the deceased alive on 1/5, 1961 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) 6905 Balto Blvd College Park, Md.	
DATE SIGNED 1/5/61			
PHYSICIAN'S NAME (Type) Thomas A Christensen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 9, 1961	
22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md..	
24a. REC'D BY REGISTRAR Jan 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. King	

George's

Maryland

George's

Hyattsville

Hyattsville

6508 Vermont St.

6508 Vermont St. (Hyattsville, Md.)

Galt

Galt

Galt

1/1/55

1/1/55

1/1/55

U.S.A.

Virginia

None

None

None

None

U.S. (Galt) (Hyattsville, Md.)

None

None

None

Hyattsville, Md.

Hyattsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1001

00993

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)			c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 731 - 5th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Last Crutchfield				4. DATE OF DEATH Month January Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/11/09	
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Walter Crutchfield				14. MOTHER'S MAIDEN NAME Annie Bolden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Carcinoma of pancreas; early cirrhotic changes							INTERVAL BETWEEN ONSET AND DEATH 4 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1960 to 1/12/1961 , that (I) (we) last saw the deceased alive on 1/12 1961 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/12/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) 1-17-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY CHAPEL HILL CEMETERY		23d. LOCATION (City, town, or county) (State) CHAPEL HILL, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St. N.E. Philip Ray A-437				25a. REC'D BY REGISTRAR DATE JAN 19 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1002

CERTIFICATE OF DEATH

Reg. Dist. No. 66994

1. PLACE OF DEATH a. COUNTY Pr George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside 19	
d. NAME OF HOSPITAL (If not in hospital, give street address) 223 Maple Rd.		d. STREET ADDRESS 223 Maple Rd.	
3. NAME OF DECEASED (Type or print) Mr. Curtis I Deily		4. DATE OF DEATH Month January Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-83
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm. H.H. Deily		14. MOTHER'S MAIDEN NAME Valeria Faisey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs Lois O'Connor		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) Diabetes Mellitis			INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years 1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterioscleotic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 , 19____, to Jan 16, 1961 , that I last saw the deceased alive on Jan. 3, 1961 , 19____, and that death occurred at 2:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Marlboro Pike, S. E. DATE SIGNED			
ACTUAL SIGNATURE Sidney W. Lowry		PHYSICIAN'S NAME (Type) S. W. Lowry, M.D.	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF 1-18-61	
22c. NAME OF CEMETERY OR CREMATORY Rosemont		22d. LOCATION (City, town, or county) (State) Bloomsburg. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, Washington D.C.		24a. REC'D BY REGISTRAR Jan 19 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PERSONAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS	
POST-MORTEM EXAMINATION		AUTOPSY REPORT	
CERTIFICATE OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1003

CERTIFICATE OF DEATH

00995

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. LENGTH OF STAY IN 1b 5 mo. 4 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First HELEN Middle - Last DONOGHUE		4. DATE OF DEATH Month January Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cashier		12. KIND OF BUSINESS OR INDUSTRY George Wash. Hosp. Washington, D.C.	
13. BIRTHPLACE (State or foreign country) Washington, D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Lawrence Rucker		16. MOTHER'S MAIDEN NAME Nellie Cavanaugh	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 224-12-2371	
19. INFORMANT Person		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (prob. thrombosis) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis; Hypertensive Cardiovascular Disease; Myocardial Infarction, remote; Coronary insufficiency.			
INTERVAL BETWEEN ONSET AND DEATH 3 das.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Aug. 3 19 60 to Jan. 7 19 61 , that (I) (we) lost saw the deceased alive on Jan 7 1961 , and that death occurred on 210A AM, from the causes and on the date stated above. 22a. SIGNATURE Moe Weiss M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Jan. 7, 1961 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/11/61 23c. NAME OF CEMETERY OR CREMATORY MT Olivet 23d. LOCATION (City, town, or county) (State) Wash. D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE W W Chambers & Co		25. REGISTRAR'S SIGNATURE Arthur S. Kram	
ADDRESS 517 11th ST SE		25a. REC'D BY REGISTRAR DATE JAN 12 '61	

CERTIFICATE OF DEATH

1003

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

[Faint, mostly illegible text at the bottom of the page, possibly a continuation of the certificate or a separate document.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1004

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 66986

1. PLACE OF DEATH a. COUNTY Prince George's, MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 8519 Potomac Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Howard Middle George Last Dunn			4. DATE OF DEATH Month January Day 3 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/84	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads, Retired		11. BIRTHPLACE (State or foreign country) Franklin Town, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME James Dunn		
14. MOTHER'S MAIDEN NAME Martha Stewart			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. 217-14-7426			17. INFORMANT Rebecca Dunn, Wife Address Potomac 8519 Potomac Ave., Berwyn		
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural & subarachnoid hemorrhage DUE TO Trauma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell to floor					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor			
20c. TIME OF INJURY Month, Day, Year 3:00 a.m. 12/25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Berwyn		20g. (County) Prince George		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James I. Boyd, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-3-61	
EXAMINER'S NAME (Type) James I. Boyd, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery	
22d. LOCATION (City, town, or county) Charles Town, West Virginia		22e. (State) West Virginia		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR JAN 5 '61	
24b. REGISTRAR'S SIGNATURE John S. Kraus					

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED [REDACTED]</p>		<p>AGE [REDACTED]</p>		<p>SEX [REDACTED]</p>	
<p>DATE OF DEATH [REDACTED]</p>		<p>TIME OF DEATH [REDACTED]</p>		<p>PLACE OF DEATH [REDACTED]</p>	
<p>CAUSE OF DEATH [REDACTED]</p>		<p>MANNER OF DEATH [REDACTED]</p>		<p>PLACE OF BURIAL [REDACTED]</p>	
<p>NAME OF MEDICAL EXAMINER [REDACTED]</p>		<p>ADDRESS OF MEDICAL EXAMINER [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	
<p>NAME OF CORONER [REDACTED]</p>		<p>ADDRESS OF CORONER [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	
<p>NAME OF FUNERAL HOME [REDACTED]</p>		<p>ADDRESS OF FUNERAL HOME [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	
<p>NAME OF BURIAL PLACE [REDACTED]</p>		<p>ADDRESS OF BURIAL PLACE [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	
<p>NAME OF WITNESS [REDACTED]</p>		<p>ADDRESS OF WITNESS [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	
<p>NAME OF SIGNER [REDACTED]</p>		<p>ADDRESS OF SIGNER [REDACTED]</p>		<p>CITY AND STATE [REDACTED]</p>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 FilmG280 2-2-61 et

00997

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 9406 Adelphi Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William George Dutton		4. DATE OF DEATH Jan 2 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker Ship Yard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Great Briton		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 127-14-1318							
17. INFORMANT Mr. Everett Wilson		Address Same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive heart failure 442 * DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 3, 1960		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/61		22c. NAME OF CEMETERY OR CREMATORY ROCK HILL		22d. LOCATION (City, town, or country) (State) STAFFORD VA.			
23. FUNERAL DIRECTOR W.W. CHAMBERS CO.		ADDRESS 1400 CHAPIN ST NW WASHINGTON DC		24a. REC'D BY REGISTRAR JAN 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1003

James George

George

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James George

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James George

James George

James George

James George

James George

James George

James George

James George

James George

James George

James I. Ford, M.D.

Jan. 1, 1900

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00998

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chelverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
c. LENGTH OF STAY IN 1b Weed married				d. STREET ADDRESS 4414 Oliver			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kenneth Carlton Fahey		Middle Last		4. DATE OF DEATH January 10 1961		Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 24 1909	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S. &	
13. FATHER'S NAME Peter Fahey		14. MOTHER'S MAIDEN NAME Margaret Maurane		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			
16. SOCIAL SECURITY NO. 261-32-0157		17. INFORMANT Elizabeth Fahey, same as #2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute congestive heart failure (b) Coronary occlusion (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. T. Boye		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 10, 1961	
EXAMINER'S NAME (Type) James I. T. Boye		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1000
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



[Faint, mostly illegible handwritten text follows, likely containing patient information and medical findings.]

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1007

01000

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston d. STREET ADDRESS 4706 Decatur Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) GEORGE URIAS FANT		4. DATE OF DEATH Month January Day 26 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1906		9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner				10b. KIND OF BUSINESS OR INDUSTRY Restaurant				11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilton Fant				14. MOTHER'S MAIDEN NAME Nannie Cooper				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII 16. SOCIAL SECURITY NO. 578-05-8566 17. INFORMANT Mrs. Dorothy M. Fant, Address 4706 Decatur St., Edmonston, Maryland.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>James I. Boyd</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 26, 1960. Address (Street, city, town, or county)													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or country) Colmar Manor,		(State) Md.					
23. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Maryland				24a. REC'D BY REGISTRAR JAN 30 '61		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>			

MEDICAL CERTIFICATION

• 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
1008
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00999

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deland Memorial Hospital</u>				d. STREET ADDRESS <u>914 Montgomery St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cara Elizabeth Parrish</u>				4. DATE OF DEATH Month Day Year <u>January 27 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Henning Beall</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Burdette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Calvin Parrish Landville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Frailty & General Attherosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Frailty & General Attherosclerosis</u> DUE TO (c) <u>Frailty & General Attherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Landville Prince George Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 11 1960</u> , to <u>January 27 1961</u> , that (I) (we) last saw the deceased alive on <u>January 27 1961</u> , and that death occurred at <u>7:41</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 29 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tray Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Landville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>De Witt Connelton, Landville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1009

01001

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>So</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>6103 Sargent Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>HOWELL</u> Last <u>Farlin</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>July 29, 1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer Ret. Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Interlaken, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>F. Roger Eastman, 6103 Sargeant Road, Hyatts., Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-20-0</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alumina</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 1960</u> to <u>1/7</u> 19 <u>61</u> , that (I) (we) lost the deceased alive on <u>1/7</u> 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Norman D. ComEAU</u>				22b. DATE SIGNED <u>1/7/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Norman COMEAU</u>	
22d. ADDRESS <u>3503 Ring W. Mt Rainier Md.</u>				22e. REC'D BY REGISTRAR <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>January 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				25. ADDRESS <u>2801 Cleveland Ave. Riverdale</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CENTROLE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01002

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights c. LENGTH OF STAY in 1b 5 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Behind 5911 K St.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 5911 K Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas First GALLOWAY Middle Last		4. DATE OF DEATH Jan Month 9 Day 19 61 Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1886 9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Galloway	
14. MOTHER'S MAIDEN NAME Rhoda Duckett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Betty Patterson, 722 61st Ave., Hgts., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Slept in unheated building very cold	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan 9, 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Fairmont Heights Pg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I Boyd, M.D.		DATE SIGNED 10 Jan 1961	
22a. BURIAL CREMATION, REMOVAL (Specify) 1-14-61	22b. DATE THEREOF 1-14-61	22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Park	22d. LOCATION (City, town, or country) (State) Hightland PK Md
23. FUNERAL DIRECTOR ADDRESS HENRY S. WASHINGTON & SONS, 4927 Deane Ave., NE, Wash., D.C.		24a. REC'D BY REGISTRAR Jan 16 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JO. 1. 1991

U. N. K. 1904

1 FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11063

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 24 Dupont Heights d. STREET ADDRESS 4420 Shaw Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Evelyn		4. DATE OF DEATH Month January Day 14 Year 19 61		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 70 yrs.		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70		11. IF UNDER 24 HRS. Days 70		12. IF UNDER 24 HRS. Hours 70		13. IF UNDER 24 HRS. Min. 70							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME Asbury Jackson				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. ***				17. INFORMANT William Gantt (Son)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Jan. 14th. 1961											
ACTUAL SIGNATURE JAMES I. BOYD				EXAMINER'S NAME (Type or print) JAMES I. BOYD				Address (Street, city, town, or county) 30 H St., N.E.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/18/61				22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				22d. LOCATION (City, town, or country) Suitland, Maryland			
23. FUNERAL DIRECTOR Arthur S. Howard				ADDRESS 30 H St., N.E.				24a. REC'D BY REGISTRAR DATE JAN 17 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Howard															

TOP SECRET
REF ID: A66666

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1011

1011 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

James George Jackson
B.O.B. 1901
1200 1st Ave.
St. Louis, Mo.
TO
U.S.A.
Army Jackson
William George (son)
214 1st St. N.E.
Washington, D.C.
James George Jackson
B.O.B. 1901
1200 1st Ave.
St. Louis, Mo.
TO
U.S.A.
Army Jackson
William George (son)
214 1st St. N.E.
Washington, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C1004

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East Pines			
c. LENGTH OF STAY IN 1b Dead on arrival				d. STREET ADDRESS 5811 64th Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nathan Gordon				4. DATE OF DEATH Month January Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1898	
9. AGE (in years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? 1				13. FATHER'S NAME LEWIS, GORDON			
14. MOTHER'S MAIDEN NAME REBECCA SHERLIS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 1				17. INFORMANT Mrs Viola Virginia Gordon, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute congestive heart failure DUE TO (b) Myocardosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) 422.2							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) WASHINGTON				(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF JAN. 23, 1961			
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY				22d. LOCATION (City, town, or country) WASHINGTON			
23. FUNERAL DIRECTOR B. Dringman & Sons				ADDRESS 3501 14th NW.			
24a. REC'D BY REGISTRAR JAN 25 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

DATE SIGNED

1/20/61

(State)

DE

1012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Married

Lead on arrival

501 6th Avenue

Gordon

January 19, 1912

December 17, 1911

Married

REBECCA CHESTER

710 1/2 10th Avenue, New York

Route conveyed to New York

Typewritten

By Dr. D. L. [Signature]

1/20/12

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
1013
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C1005

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Andrews AFB Hospital		d. STREET ADDRESS 4669 Benning Rd, S.E.	
3. NAME OF DECEASED (Type or print) First Robert Middle NMN Last Green III		4. DATE OF DEATH Month Jan Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 21, 1961
9. AGE (In years last birthday) yrs. 192		10. IF UNDER 1 YEAR Months 192	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Green III		14. MOTHER'S MAIDEN NAME Catherine M. Siscoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Chant		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atelectasis, congenital DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days 1 1/2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 21 Jan 1961 to 23 Jan 1961, that (we) last saw the deceased alive on 23 Jan 1961 and that death occurred at 2:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Nicholas P. Haritos M.D.		22b. ADDRESS	
22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS, CAPT USAF (MC) USAF HOSP, ANDREWS AFB, WASH 25 DC		22d. DATE SIGNED 23 Jan 61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE JAN 30 '61		25c. REGISTRAR'S SIGNATURE	

2050233XV3

CERTIFICATE OF DEATH

1013

I hereby certify that on the 10th day of January 1901
at the residence of the deceased, 10, St. James's Street,
London, W., the following named person died
of the following named disease, to-wit:
The deceased was a male person, aged 45 years,
born on the 10th day of January 1856, at the residence of
the deceased, 10, St. James's Street, London, W.,
and was a resident of the same residence at the time of his death.
The deceased was a male person, aged 45 years,
born on the 10th day of January 1856, at the residence of
the deceased, 10, St. James's Street, London, W.,
and was a resident of the same residence at the time of his death.
The deceased was a male person, aged 45 years,
born on the 10th day of January 1856, at the residence of
the deceased, 10, St. James's Street, London, W.,
and was a resident of the same residence at the time of his death.

J. C. M. M. M.

Witness

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1014
CERTIFICATE OF DEATH

Reg. Dist. No. 02220

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Southern Maryland Hospital Center Rt. 1				d. STREET ADDRESS Brandywine			
3. NAME OF DECEASED (Type or print) First Middle Last NELSON Ambrose Grimes				4. DATE OF DEATH Month Day Year JAN. 23 1961			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1888	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov. employee Oper. (U.S. Gov.)				10b. KIND OF BUSINESS OR INDUSTRY Embossograph		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Warren Grimes			
14. MOTHER'S MAIDEN NAME Sarah Hyde				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --			
16. SOCIAL SECURITY NO. ---				INFORMANT Mrs. Edith M. Grimes Address Rt. 1, Box 184 Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) cardiovascular disease DUE TO (c) arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 minutes 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1/11 , 19 61 , to 1/23 , 19 61 , that I last saw the deceased alive on 1/23 , 19 61 , and that death occurred at 10:57 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred R. Lapin		ADDRESS (Street, city or town, state) Clinton, Md.		DATE SIGNED 1/23/61			
PHYSICIAN'S NAME (Type) Alfred R. Lapin, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/26/61	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.	22d. LOCATION (City, town, or county) (State) Baden, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Goss - Upper Marlboro, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 14 '61	24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
15M 9/59

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Item 9 Film G201 2-15-61 et

1076

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1015

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

61066

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md. c. LENGTH OF STAY IN lb 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5100 Pierce St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie A. Gross		4. DATE OF DEATH Month Day Year Jan 14 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/186
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sam Hughes		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address 4408 Queensbury Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis DUE TO (b) pt hemiplegia DUE TO (c) General Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1959 to Jan 14 1961, that (I) (we) last saw the deceased alive on Jan 13 1961, and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. W. Malin M.D.		22b. DATE SIGNED 1-14-61	
22c. PHYSICIAN'S NAME (Type) L. W. Malin MD		22d. ADDRESS Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-19-61		23b. DATE THEREOF 1-19-61	
23c. NAME OF CEMETERY OR CREMATORY Carver Memorial		23d. LOCATION (City, town, or county) (State) Murfreesboro Md	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S Washington + Son		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
ADDRESS 4925 Beane Ave		25b. REGISTRAR'S SIGNATURE Arthur S. Krauss	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1016
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01007

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #19 - 9th Street				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 04 Bowie d. STREET ADDRESS #19 - 9th. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD RICHARD GRUBER				4. DATE OF DEATH Jan 21, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24 1913	
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Gruber				14. MOTHER'S MAIDEN NAME McKelvie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. YES		17. INFORMANT Same #2 Mrs Page Burgner		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pulmonary tuberculosis 002X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Jan 21, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 24, 1961		22c. NAME OF CEMETERY OR CREMATORY Alsace Cemetery		22d. LOCATION (City, town, or country) (State) Reading, Penna	
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md ADDRESS				24a. REC'D BY REGISTRAR JAN 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

THE KING
STATES DEPT

1016

Prince George's

Boyle

412 - 2nd Street

White

Section

Scout Order

No

Yes

Not a Scout

Boyle

July 21, 1916

412 - 2nd Street

Boyle

Prince George's

Prince George's

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1017
CERTIFICATE OF DEATH
61008

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hos p.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, d. STREET ADDRESS 2420- Lake Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frances First Middle H. Last Hall		4. DATE OF DEATH January 30 Month Day Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Monty				14. MOTHER'S MAIDEN NAME Mary White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Norman D. Hall Husband -same as above Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause } (b) My hypertension (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan 1, 1960, to 1/30, 1961, that (I) (the) last saw the deceased alive on 1/30, 1961, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Barry Rosenberg M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Barry Rosenberg				22d. ADDRESS 5102 Annapolis Rd. Bladensburg, Md.			
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE THEREOF 2-2-61		23c. NAME OF CEMETERY OR CREMATORY Riverside		23d. LOCATION (City, town or county) (State) Plattsburgh, N.Y.	
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. D.C.				25a. REC'D BY REGISTRAR FEB 2 '61 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

210

Prince George.

• • • • •

• • •

11-11

CERTIFICATE OF DEATH

Reg. Dist. No.

1018

1. PLACE OF DEATH a. COUNTY Prince Georges B MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS Woodmore Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodmore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jesse Lee HALL Jr		4. DATE OF DEATH Month Day Year Jan 8 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1928
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Instructor		10b. KIND OF BUSINESS OR INDUSTRY Own School	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Lee Hall		14. MOTHER'S MAIDEN NAME Dorothy C. Waesche	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Jesse Lee Hall- Same as Item #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Uterine DUE TO (b) Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Several years 32 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to 1/8 1961, that I last saw the deceased alive on 1/7 1961, and that death occurred at 1:00 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz M.D.		ADDRESS (Street, city or town, state) RFD Bowie Md	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 1/8/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cemetery		22d. LOCATION (City, town, or county) (State) Mitchellville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Marlboro, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAVFLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1 1019 Item 2 Film G280 2-6-61 et 1019 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. 1010

1019

CERTIFICATE OF DEATH

Reg. Dist. No.

1010

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland D.C.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		d. STREET ADDRESS <u>1867 Wyoming Ave. Lasalle Road / 1149221</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE M HALL</u>		4. DATE OF DEATH Month Day Year <u>1 28 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Cross</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Andrews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Sanford B. Leach-1608 44th St., NW Wash., DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive heart failure.</u> DUE TO (b) <u>Cardiomegaly</u> DUE TO (c) <u>Hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cometose - several months of cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>Years</u> <u>Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Jan</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>61</u> , and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4323 HARVARD ST SILVER SPRING, MD</u> DATE SIGNED <u>Richard P. Delaney</u>			
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D.			
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or County) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., SE DC3</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1919

1

CERTIFICATE OF DEATH

Reg. Dist. No.

1020

1011

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4113 Woodberry Street-				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vera Middle Millicent Last Hammond				4. DATE OF DEATH Month January Day 23 Year 1961-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 23, 1888	
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Howard Stephens				14. MOTHER'S MAIDEN NAME Williamina Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
INFORMANT Mildred H Speicher				Address University Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 59 , to Jan 14 , 19 61 , that I last saw the deceased alive on Jan 14 , 19 61 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED 1-23-61							
ACTUAL SIGNATURE Richard L. Whelton				PHYSICIAN'S NAME (Type) Richard L. Whelton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 25, 1961		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE JAN 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kenna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1930

UNIVERSITY OF CHICAGO

University Park 21
Princeton University
Princeton, New Jersey

1111 Woodbury Street
Chicago, Illinois

John D. Millington
January 20, 1930

Dear Mr. Millington:

I have your letter of January 17, 1930.

Henry Howard Stephens

no more

Handwritten notes and signatures:
C. C. ...
...
...

Jan 22, 1931 London Park Cemetery
Baltimore, Maryland
E. Lewis's Sons, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1021										1012									
1021										1012									
1021										1012									
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1 Brandy wine				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					d. STREET ADDRESS Box 283									
3. NAME OF DECEASED (Type or print) First Richard Middle E. Last Hawkins					4. DATE OF DEATH Month January Day 28 Year 19 61														
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/1/06		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10b. KIND OF BUSINESS OR INDUSTRY Pri. Geo. Co., Md.					11. BIRTHPLACE (State or foreign country) U. S. A.					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Bernie O. Hawkins					14. MOTHER'S MAIDEN NAME Helenetta Holladay														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT James R. Hawkins Taylor, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151 X DUE TO Suppurative peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adverse to the stomach DUE TO (c) Adverse to the stomach										INTERVAL BETWEEN ONSET AND DEATH 6									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1/4 19 61 , to 1/28 19 61 , that (I) (we) last saw the deceased alive on 1/28 19 61 , and that death occurred at 9:07 PM , from the causes and on the date stated above.																			
22a. SIGNATURE Wm. A. Holbrook					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1/29/61					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Wm. A. Holbrook					22d. ADDRESS 4500 College Ave., College Park, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) burial					23b. DATE THEREOF 1-31-61					23c. NAME OF CEMETERY OR CREMATORY St Thomas					23d. LOCATION (City, town, or county) (State) Brandywine Md				
24. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson					ADDRESS Aguasco, Md					25a. REC'D BY REGISTRAR JAN 30 '61					25b. REGISTRAR'S SIGNATURE William S. Thomas				

CERTIFICATE OF DEATH

1021

1011

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		Jan 15, 1910	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		New York City		Heart Disease		Natural	
Occupation		Signature of Physician		Signature of Registrar		Signature of Coroner	
Teacher		[Signature]		[Signature]		[Signature]	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister	
Jan 20, 1910		St. Paul's Church		St. Paul's Church		Rev. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1022
CERTIFICATE OF DEATH
01013

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md. c. LENGTH OF STAY IN 1b 30 min.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 6603 Wells Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ISABEL First Middle Last HAYES				4. DATE OF DEATH Month Day Year January 5 1961											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/77		9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) HARTWICH, N. Y.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME MENZO INGALLS				14. MOTHER'S MAIDEN NAME LUCENDA ROBINSON											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema. Bilateral Hydrothorax 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Myocardial Fibrosis DUE TO (c) Coronary Arteriosclerotic Heart Disease												INTERVAL BETWEEN ONSET AND DEATH 24 hours			
												years			
												years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 5 1961		(County) Jan 5 1961		(State) 1961			
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1961 to Jan 5 1961 , that (I) (we) last saw the deceased alive on Jan 5 1961 , and that death occurred at 4:15 p.m. from the causes and on the date stated above.															
22a. SIGNATURE Benjamin S. Miller				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER, M. D.				22d. ADDRESS PRINCE GEORGES COUNTY, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-REMOVAL				23b. DATE THEREOF HARTWICK SEMINARY				23c. NAME OF CEMETERY OR CREMATORY COOPERSTOWN, N. Y.				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawless Sons				ADDRESS 1756 R. Ave. N.W.				25a. REC'D BY REGISTRAR DATE JAN 9 '61				25b. REGISTRAR'S SIGNATURE Arthur E. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1023

CERTIFICATE OF DEATH

C1014

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parish - Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>3 3/4 yrs</u>		d. STREET ADDRESS <u>7400 Carroll Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Isant Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Morrison</u> Last <u>Hackman</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>22</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1866</u>
9. AGE (In years lost birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>North Scotia, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Archibald McKinnon</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE McFEE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT Address <u>Mrs C. B. Smith - (same as #1.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>Jan 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 21, 1961</u> , and that death occurred at <u>6 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Whitlock</u> M.D.		22b. DATE SIGNED <u>1-22-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>		22d. ADDRESS <u>Takoma Park MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 26, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EASTWOOD CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Lancaster Mass.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
ADDRESS <u>254 Carroll St NW</u>		DATE <u>JAN 25 '61</u>	

CERTIFICATE OF DEATH

1953

No.

Richard McPherson

Residence

White

Age 22, White

Married

1953

CERTIFICATE OF DEATH

Reg. Dist. No. 01015

1024

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTHERN MD. HOSP. CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Veronica Last Heller		4. DATE OF DEATH Month JAN. Day 4 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Mary Agnes Weisshiller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 57F-26-2022	
INFORMANT (SON)		Address RT2 BX382 CLINTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X (b) LEFT CEREBRO-VASCULAR ACCIDENT (c) HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 36 HRS. 15 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month NONE Day NONE Year NONE Hour NONE a.m. NONE p.m. NONE		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) NONE (County) NONE (State) NONE	
21. I certify that I attended the deceased from 12/23, 1960 to present , that I last saw the deceased alive on Jan. 4, 1961 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.		DATE SIGNED 1/4/61	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/7/61	22c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L CEM.	22d. LOCATION (City, town, or county) (State) SUITLAND & - RENO MD
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		24a. REC'D BY REGISTRAR DATE JAN 9 '61	
ADDRESS 577 11th ST SE		24b. REGISTRAR'S SIGNATURE Arthur S. Shaver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MICHIGAN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7-59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02229

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro Twp				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro 04			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oak Creek Highway				d. STREET ADDRESS Old Creek Highway			
3. NAME OF DECEASED (Type or print) Male First Middle Last				4. DATE OF DEATH January 28 1961			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 9, 1960	
9. AGE (In years last birthday) yrs. 3		10. MONTHS 19		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Vincent T. Holmer				14. MOTHER'S MAIDEN NAME Clara Hamilton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) none				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs Clara Holmer, same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or country) (State) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home- Upper				24a. REC'D BY REGISTRAR FEB 14 '61			
ADDRESS Upper				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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FOR THE
DEPARTMENT

(1)

RECEIVED
JAN 10 1935
MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1027

CERTIFICATE OF DEATH

61017

1. PLACE OF DEATH e. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 665 24th St., N. E.			
3. NAME OF DECEASED (Type or print) First John Middle - Last Holmes, Sr.				4. DATE OF DEATH Month 1 Day 23 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months - Days -		IF UNDER 24 HRS. Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Capital Transit Company			
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Holmes				14. MOTHER'S MAIDEN NAME Martha Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Chronic pyelonephritis with renal failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus, uncontrolled; arteriosclerotic heart disease; left inguinal hernia				INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6/15/60 9:25¹⁹ to 1/23/1961 that (I) (we) last saw the deceased alive on 1/23/1961, and that death occurred at A.M., from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/23/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)		23b. DATE THEREOF 1/28/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart, 30 H St. NE				25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1023

John George

John George (Jr.)

John George (Jr.)

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
C1018											
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3607 Longfellow Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID CLINTON HONEA						4. DATE OF DEATH Month January Day 28 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 9, 1954		9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 28 Days 1961 IF UNDER 24 HRS. Hours 1961 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY At School				11. BIRTHPLACE (State or foreign country) Takoma Park, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Edward Honea						14. MOTHER'S MAIDEN NAME Annie Juanita Breece					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Annie J. Honea, Address 3607 Longfellow St., Hyatts., Md. Apt. 5					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide poisoning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an apartment that collapsed							
20c. TIME OF INJURY Month, Day, Year 10 5 1-28 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hyattsville P.S.		(County) Wol (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 29, 1961.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		22d. LOCATION (City, town, or country) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR ADDRESS W. W. CHAMBERS CO., Riverdale, Maryland.						24a. REC'D BY REGISTRAR DATE JAN 31 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1029

CERTIFICATE OF DEATH

1019

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Col. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale				c. LENGTH OF STAY IN 1b 4 mo.; 9 das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael First J. Middle Horan Last				4. DATE OF DEATH Jan. Month 14 Day 1961 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		11. IF UNDER 24 HRS. Months 11 Days 11 Hours 11 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME David Horan				14. MOTHER'S MAIDEN NAME Annie Moran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Right Lung with local and regional metastases DUE TO (b) Pulmonary tuberculosis, active DUE TO (c) lying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 11 mo. (by history)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 5 1960 to Jan. 14 1961 that (I) (we) last saw the deceased alive on Jan 14 1961 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE Jan. 14, 1961 SIGNED			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/18/61		23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Timothy Naulon - 3831 - GA. AVE. NW				25a. REC'D BY REGISTRAR JAN 19 '61		25b. REGISTRAR'S SIGNATURE Charles L. Kline	

STATE OF TEXAS
COUNTY OF DALLAS

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City of Dallas

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1030

CERTIFICATE OF DEATH

Reg. Dist. No.

11020

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland				c. LENGTH OF STAY IN 1b Ten months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home				d. STREET ADDRESS St. George Hotel			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle B. Last Hubbard				4. DATE OF DEATH Month January Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 12, 1879	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Frank E. Lord				14. MOTHER'S MAIDEN NAME Mary Ellen Satchel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Sacred Heart Home, West Hyattsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) ① PNEUMONIA DUE TO (b) ② ARTERIOSCLEROTIC HEART DISEASE 1 year DUE TO (c) ③ GENERALIZED ARTERISCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from MAR 12, 1960 to JAN 14, 1961 , that I lost saw the deceased alive on JAN 12, 1961 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F Collins M.D.				ADDRESS (Street, city or town, state) 332- H ONE DATE SIGNED			
PHYSICIAN'S NAME (Type) THOMAS F. COLLINS, M.D.				WASHINGTON DC.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-14-61		22c. NAME OF CEMETERY OR CREMATORY SHEFFIELD		22d. LOCATION (City, town, or county) (State) SHEFFIELD, MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS 3821-14th ST. N.W. D.C.		24a. REC'D BY REGISTRAR DATE JAN 17 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>6428 Sligo mill Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Compton</u> Last <u>Hunt</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph (J) Hunt</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son - Geo. W. Hunt, Sr.</u> Address <u>1937 Howard St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, common bile duct</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with metastasis.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> 19 <u>60</u> to <u>Jan 28</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>Jan 28</u> 19 <u>61</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Simpson, Jr.</u>		22b. DATE SIGNED <u>1/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson, Jr.</u>		22d. ADDRESS <u>6216 N H Ave NE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-31-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., SEDC</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61022

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Richmond Hill			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8731- 113rd Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Josephine		First T		Middle Hutchison		Last 19 61	
4. DATE OF DEATH Jan 18		Month 18		Day 19		Year 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 July 1883		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jeremiah Costigan				14. MOTHER'S MAIDEN NAME Johannah Drennen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John K Hutchison		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO 3 days (c) pleural effusion from metastatic Ca. 2 months							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10 1960 to 1/18 1961 , that (I) (we) last saw the deceased alive on 1/18 1961 , and that death occurred at 1.10AM from the causes and on the date stated above.							
22a. SIGNATURE Dr. F. Musser., M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/18/61	
22c. PHYSICIAN'S NAME (Type) Dr. F. Musser., M.D.				22d. ADDRESS 4410 74th Ave., Beallmeade, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation Jan 19, 1961		23b. DATE THEREOF Jan 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Richmond Hills		23d. LOCATION (City, town, or county) (State) New York	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				25a. REC'D BY REGISTRAR JAN 20 61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1033											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D. O. A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Farmont Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6006 Sheriff Road S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Henry Jackson				4. DATE OF DEATH Month January Day 31 Year 1961							
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1884		9. AGE (In years last birthday) 75 76 yrs.		IF UNDER 1 YEAR Months 1 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason				10b. KIND OF BUSINESS OR INDUSTRY Building				11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joshua Jackson				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 308 11th Street S.E.				17. INFORMANT Madelain Kell, Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive Jaundice DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of the Stomach with Metastasis (c), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 										INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 							
20c. TIME OF INJURY Hour e.m. p.m. 		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED January 31, 1961			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-4-61				22b. DATE THEREOF 2-4-61				22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Park Highland Park Md			
23. FUNERAL DIRECTOR H.S. Washington				ADDRESS 4925 Deane Ave NE				24a. REC'D BY REGISTRAR FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR THE
FEDERAL BUREAU OF INVESTIGATION

1933

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61024

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 6917 Adel Street Seat Pleasant d. STREET ADDRESS 6917 Adel St., Seat Pleasant e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWARD First ARTHUR Middle JEWELL Last			4. DATE OF DEATH Month January Day 5, Year 19 61.		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 19, 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 5, Days 19 Hours 61. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Fairfax, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edwin C. Jewell			
14. MOTHER'S MAIDEN NAME Laura Virginia Havenor				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Peacetime USN unknown	
16. SOCIAL SECURITY NO. Mrs. Ruth Yowell, 6504 A St. Seat Pleasant, Md.				17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra cerebral hemorrhage DUE TO 44+3X Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. TIME OF INJURY Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town) Seat Pleasant		20e. (County) Prince Georges		20f. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE JAMES I. BOYD, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 5, 1961.	
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 10, 1961		22c. NAME OF CEMETERY OR BURIAL PLACE Arlington National	
22d. LOCATION (City, town, or country) Arlington Virginia		22e. (State) Virginia		22f. (Country) USA	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR JAN 11 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

THE STATE
HEALTH DEPT.



1934

Prison Georgia County

Georgia

Prison Georgia County

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Male White

Prison

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Prison

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JAMES I. ROY, M. D.

January 5, 1934

Prison

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MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3120 Powder Mill Rd. Paint Branch Nursing Home		d. STREET ADDRESS 1021 Otis Street N. E.	
3. NAME OF DECEASED (Type or print) First Hilma Middle C. Last Jones		4. DATE OF DEATH Month January Day 7 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abram Wiklund	
14. MOTHER'S MAIDEN NAME Christina Hendrikess Dotter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease (c) generalized arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinsons Syndrome (b) 3/24/58 fracture skull (c) fracture ribs 3/24/58			INTERVAL BETWEEN ONSET AND DEATH 11/7/61 14-20 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fracture ribs 3/24/58	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/1/57 to 11/7/61, that (I) was last seen the deceased alive on 12/20/60, and that death occurred on 11/7/61, from the causes and on the date stated above.			
22a. SIGNATURE John J. Sweeney M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John J. Sweeney		22d. ADDRESS 1238 Monroe St NE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/10/61	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2901 14th St. N. W. Washington, D. C.		25a. REC'D BY REGISTRAR JAN 9 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

1501

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1036

61026

1. PLACE OF DEATH COUNTY <u>Prince Georges Beltsville Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Amundale Normal Institute</u> COUNTY <u>Prince Georges Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Md</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Normal Institute Beltsville Md.</u>				d. STREET ADDRESS <u>Beltsville B. Co. Md</u>			
3. NAME OF DECEASED (Type or print) <u>Brother Denis Edward</u> First <u>HENRY</u> Middle <u>A.</u> Last <u>JUERGENS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 18 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher, Brothers</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A. Philadelphia Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ferdinand Juergens</u>				14. MOTHER'S MAIDEN NAME <u>Margaretha Hertlein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Brother Francis Benilde Beltsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u>							
DUE TO <u>422.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C-S Cardiovascular Dis</u>							
DUE TO <u>Gen'l arteriosclerosis</u>							
(c) <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renovascular disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/3/58</u> to <u>1/7</u> 19 <u>60</u> that (I) (<u>—</u>) last saw the deceased alive on <u>1/6</u> 19 <u>60</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J M Warren</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>				22d. ADDRESS <u>305 Prince George Street, Laurel Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>January 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christian Brothers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Beltsville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. CHAMBERS CO., Riverdale, Md</u>				25a. REC'D BY REGISTRAR <u>JAN 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form for a death certificate, with fields for name, date, and other details.]

1. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1037

CERTIFICATE OF DEATH

C1027

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5006 Hollywood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Barbara Middle Anne Last Kemerer				4. DATE OF DEATH Month Jan. Day 7 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1931	
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home			
13. FATHER'S NAME Cecil B Hall				14. MOTHER'S MAIDEN NAME Mildred E Sears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 577 42 5753			
17. INFORMANT James M Kemerer				Address Hollywood Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and Bilateral Hydrothorax 754.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Patent Ductus Arteriosus DUE TO (c) Congenital Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 24 hours from birth from birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 2 19 61 to Jan. 7 19 61 that (I) (we) last saw the deceased alive on Jan. 6 19 61 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles C. Hageage				22b. DATE Jan. 7, 1961			
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.				22d. ADDRESS 3308 Perry St., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 10, 1961			
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REGISTRAR DATE JAN 11 '61			
ADDRESS Hyattsville, Maryland.				25b. REGISTRAR'S SIGNATURE Charles S. Kerner			

MEDICAL CERTIFICATION

1038

CERTIFICATE OF DEATH

Reg. Dist. No.

C1028

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>		d. STREET ADDRESS <u>4305 Jan Kuren St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Core</u> Middle <u>Etta</u> Last <u>Koons</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1891</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <u>Operator boarding house - Private</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Crum</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Crail</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Jan 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>61</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7717 Carroll Ave Takoma Park Md</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		DATE SIGNED <u>1-7-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1/9/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Plymouth Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Plymouth, Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

May M. Gail

David Green

None

No

James H. Whitlock

The S. H. White Co., Boston, U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1039

CERTIFICATE OF DEATH

Reg. Dist. No.

61029

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 3V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. 6-24-56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUISA Middle KRAUSE Last KRAUSE		4. DATE OF DEATH Month January Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14-1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADOLPH SCHMIDT		14. MOTHER'S MAIDEN NAME VERONICA HOAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-01-7112	
17. INFORMANT Hosp. Records LAUREL SANITARIUM		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia (522) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial degeneration (422.1) DUE TO Cardiovascular atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral arteriosclerosis with dementia (334)			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs several yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 24-1956 to January 18 1961 , that I last saw the deceased alive on January 18, 1961 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert P. Kraemer M.D.		ADDRESS (Street, city or town, state) Laurel Sanitarium 1-18-61	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		Laurel Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1-21-61	22c. NAME OF CEMETERY OR CREMATORY Gruid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Balto. Md
23. FUNERAL DIRECTOR'S SIGNATURE Henry W Jenkins & Sons Co		ADDRESS 4905 York Rd	
24a. REC'D BY REGISTRAR JAN 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

I, Dr. J. H. Smith, of the County of Franklin, State of North Carolina, do hereby certify that on the 10th day of August, 1920, at Franklin, N.C., died John H. Smith, aged 65 years, of the County of Franklin, State of North Carolina, who was born on the 15th day of January, 1855, at Franklin, N.C., and who was a resident of Franklin, N.C. at the time of his death.

The cause of death was Heart Disease.

Signed and sealed this 10th day of August, 1920.

Dr. J. H. Smith
 Physician

I, John H. Smith, of the County of Franklin, State of North Carolina, do hereby certify that the above is a true and correct copy of the original as the same appears in the records of the County of Franklin, State of North Carolina.

Signed and sealed this 10th day of August, 1920.

John H. Smith
 Clerk

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME
5M 7/59

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1030											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brightseat						c. LENGTH OF STAY IN lb 42 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brightseat Road						d. STREET ADDRESS Brightseat Road					
3. NAME OF DECEASED (Type or print) William Herman Kuenne						4. DATE OF DEATH January 6 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1905		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Volkmar Kuenne						14. MOTHER'S MAIDEN NAME Bertha Morganegg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Raymond Kuenne, same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dementia praecox										INTERVAL BETWEEN ONSET AND DEATH	
300.7 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Refused food was badly nourished											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/9/61		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or country) (State) Forestville, Md.			
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home - Upper Marlboro						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
						JAN 16 '61		Arthur S. Kraus			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14
FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.											
1041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
C1051											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 6017 Inwood St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward First CLARENCE Middle KUHN Last			4. DATE OF DEATH January Month 6 Day 19 61 Year								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1920		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY Evening Star Newspaper Jimthorp, Penns.				11. BIRTHPLACE (State or foreign country) U.S.A.			
13. FATHER'S NAME Edwin Kuhn				14. MOTHER'S MAIDEN NAME Mary Butchko							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WWII		17. INFORMANT unknown		Address Mrs. Martha R. Kuhn, 6017 Inwood St., Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 420.1	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/6/61			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia					
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md						24a. REC'D BY REGISTRAR JAN 12 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1042 CERTIFICATE OF DEATH

Reg. Dist. No.

61032

1. PLACE OF DEATH o. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. LENGTH OF STAY IN 1b <i>51</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>621-51st Avenue</i>				d. STREET ADDRESS <i>621-51st Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FLORENCE</i> First Middle Last <i>May LAMBERT</i>				4. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>1961</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-20-1880</i>	
				9. AGE (In years last birthday) yrs. <i>80</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Compher</i>				14. MOTHER'S MAIDEN NAME <i>Spring</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ruth Nairn</i> Address <i>621-51st Ave. Capitol Heights</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO <i>Generalized arteriosclerosis</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i> <i>10 yrs</i> <i>10 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 1957</i> to <i>1-4-1961</i> , that I last saw the deceased alive on <i>1-4-1961</i> , and that death occurred at <i>10:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter Duus</i> M.D.				ADDRESS (Street, city or town, state) <i>6124 Central Ave</i>		DATE SIGNED <i>1-4-61</i>	
PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>				<i>Capitol Heights Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 7, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Addison Chapel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Seat Pleasant Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons Hyattsville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 9 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>PETER J. DONNELLY</u></p>	
<p>2. Date of death: <u>1954</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Date of birth: <u>1900</u></p>	
<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>	
<p>8. Occupation: <u>None</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of filing: <u>1954</u></p>	

AGE IN YEARS

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1043

CERTIFICATE OF DEATH

C1033

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		d. STREET ADDRESS Glenbrook Road	
3. NAME OF DECEASED (Type or print) KURT M LONDON		4. DATE OF DEATH JANUARY 3 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 JAN 1908
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY MILITARY SERVICE	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PERRY OLIVER LONDON		14. MOTHER'S MAIDEN NAME HELEN HEMPEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1926-1958		16. SOCIAL SECURITY NO. 1926-1958	
17. INFORMANT TRUMAN LONDON (BROTHER)		Address [REDACTED]	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Renal and Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic lymphatic leukemia DUE TO (c) Chronic lymphatic leukemia		INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 3 days. 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 16 DEC 1960 to 3 JAN 1961 that (I) (we) last saw the deceased alive on 3 JAN 1961 and that death occurred at 7:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Andrew W. Butchko		22b. DATE SIGNED 3 January 1961	
22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF MC		22d. ADDRESS USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi		25a. REC'D BY REGISTRAR JAN 9 '61	
ADDRESS 816 H St., NE, Wash, DC		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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WILLIAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

1045

CERTIFICATE OF DEATH

Reg. Dist. No.

1035

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2311 Kirby Drive		d. STREET ADDRESS 12311 Kirby Drive	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last LOWE		4. DATE OF DEATH Month January 3rd, Day 3rd, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30th, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None--Infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Harry Leroy Lowe		14. MOTHER'S MAIDEN NAME Adelaide Andrews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Adelaide A. Lowe, 2311 Kirby Dr. Wash. 21, D.C.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Dec 30, 1960, to Jan 3, 1961, that I last saw the deceased alive on Jan 1, 1961, and that death occurred at 1:30P M, from the causes and on the date stated above. ACTUAL SIGNATURE R. J. Terrafranca M.D. # 8 Barney Circle, S.E. DATE SIGNED 1/3/1961 PHYSICIAN'S NAME (Type) R. J. Terrafranca Washington, D.C. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/5/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 22d. LOCATION (City, town, or county) (State) Suitland, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS COMPANY, 517--11th St. S.E. Wash. DC 24a. REC'D BY REGISTRAR DATE JAN 5 '61 24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1923

2-1-1923

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Sex]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. CAUSE OF DEATH [Cause of death]</p>		<p>8. PLACE OF DEATH [Place of death]</p>	
<p>9. DATE OF DEATH [Date of death]</p>		<p>10. TIME OF DEATH [Time of death]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>13. SIGNATURE OF WITNESS [Signature]</p>		<p>14. SIGNATURE OF DECEASED [Signature]</p>	
<p>15. SIGNATURE OF DECEASED [Signature]</p>		<p>16. SIGNATURE OF DECEASED [Signature]</p>	
<p>17. SIGNATURE OF DECEASED [Signature]</p>		<p>18. SIGNATURE OF DECEASED [Signature]</p>	
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<p>99. SIGNATURE OF DECEASED [Signature]</p>		<p>100. SIGNATURE OF DECEASED [Signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1046 CERTIFICATE OF DEATH

61036

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Mathews		4. DATE OF DEATH Month Day Year Jan 7 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 NOV 1907
9. AGE (In years lost birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier	
11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Berte		14. MOTHER'S MAIDEN NAME Elizabeth Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 4-16X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia rt due to C.V.A.		INTERVAL BETWEEN ONSET AND DEATH 1 hr 30 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to 7 Jan 1961 1961, that (I) (we) last saw the deceased alive on 7 Jan 1961 and that death occurred at 11:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Peter Duus		22b. DATE SIGNED 1/7/60	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus, Md.D.		22d. ADDRESS 6124 Central Ave. Capitol Hghts., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61	
23c. NAME OF CEMETERY OR CREMATORY L.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Briston, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Murphy		25. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md		25a. REC'D BY REGISTRAR 10 JAN 10 '61	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5.6 Film G279 1-27-61 et

CERTIFICATE OF DEATH

Reg. Dist. No. **61037**

1047

Item 13 Film G284 4/4/61 iwk

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bell's Nursing Home for Children				d. STREET ADDRESS 3407 Bellview Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph		First Joseph		Middle Edward		Last Mazur		
4. DATE OF DEATH Month Jan.		Day 23,		Year 19 61				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/14/60		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS. Days 9 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Mazur				14. MOTHER'S MAIDEN NAME Elizabeth Bobalik				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Address Joseph Mazur Same as # 2 (Father)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus (internal) marked 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Acute respiratory collapse DUE TO (c) 								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>7/14</u>, 19<u>60</u>, to <u>1/23</u>, 19<u>61</u>, that I last saw the deceased alive on <u>1/23</u>, 19<u>61</u>, and that death occurred at <u>8:00 A.M.</u>, from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) <u>6905 Baob Bhd</u>				
PHYSICIAN'S NAME (Type) <u>Collage Park, Md</u>				DATE SIGNED <u>1/23/61</u>				
22a. BURIAL, CREMATION, REMQVAL (Specify) Burial		22b. DATE THEREOF 1/24/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JAN 24 '61		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>								

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Figure 1

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			
c. LENGTH OF STAY IN lb D.O.A.				d. STREET ADDRESS 623 Sherdian St			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marvin (NMI) McKEE				4. DATE OF DEATH January 14 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 24 March 1906	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass. Cashier				10b. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John McKee			
14. MOTHER'S MAIDEN NAME Parthenia Brummett				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 579-09-1781				17. INFORMANT Mary E. McKee (Same as # 2) (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1/17/61			
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				22d. LOCATION (City, town, or country) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC				24a. REC'D BY REGISTRAR JAN 25 '61			
ADDRESS SILVER SPRING, MD.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

DATE SIGNED
Jan. 14th. 1961

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DOI: 10.1002/for

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1050

CERTIFICATE OF DEATH

Reg. Dist. No. (1040)

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Chillum Heights)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Hyattsville (Chillum Heights)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 Somerset Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH KEMPSTER MORGAL				4. DATE OF DEATH Month Day Year Jan. 17 1961			
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 28, 1891		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Toolmaker.		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Morgal				14. MOTHER'S MAIDEN NAME Margaret Lynch.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes. (If yes, give war or dates of service) WW +		16. SOCIAL SECURITY NO. yes		17. INFORMANT Hazel Mrs. Hazel Morgal - wife		Address - same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular dis. DUE TO (c) (years)							INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Not.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 13 , 19 61 , to Jan. 17 , 19 61 , that I last saw the deceased alive on Jan. 13 , 19 61 , and that death occurred at 10:15 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Simpson Jr.				ADDRESS (Street, city or town, state) 6216 N.H. Ave N.E.		DATE SIGNED 1/17/61	
PHYSICIAN'S NAME (Type) William F. Simpson Jr.				ADDRESS Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/61		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. - 2901 14th St., N.W.				24a. REC'D BY REGISTRAR DATE JAN 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Age at Death

Place of Death

Sex

Color of Skin

Place of Birth

Married

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RECEIVED
JAN 11 1901
V. 1100

RECEIVED
JAN 11 1901
V. 1100

RECEIVED
JAN 11 1901
V. 1100

MASSACHUSETTS DEPARTMENT OF HEALTH
BIRTH AND DEATH RECORDS
JAN 11 1901
V. 1100

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1051 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1041

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly,</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 1 / 1961</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Md. Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stewart Wm Morris</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jean Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>pneumonia</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> 19 <u>61</u> , to <u>1-25</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>61</u> , and that death occurred at <u>3/35</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. J. Modlin</u>				22b. DATE SIGNED <u>1/26/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr/A.J. Modlin. M.D.</u>				22d. ADDRESS <u>300 Montrose Ave. , Laurel, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/27/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Modlin</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William J. Modlin</u>							

2046201KV3

2

[Faint, illegible handwriting]

[Faint, illegible handwriting]

1052

CERTIFICATE OF DEATH

Reg. Dist. No.

1042

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
c. LENGTH OF STAY IN 1b <u>about 2 yrs.</u>		47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3711-34th street</u>		d. STREET ADDRESS <u>3711-34th street</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Delores</u> First <u>D. Mulholland</u> Middle <u></u> Last		4. DATE OF DEATH <u>Jan. 25</u> Month <u>Jan.</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13. FATHER'S NAME <u>Plumbhoff</u>	14. MOTHER'S MAIDEN NAME <u>Anna K. Shisslett</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	16. SOCIAL SECURITY NO. <u>none</u>
INFORMANT <u>John J. Mulholland</u> Address <u>3711-34th St., Mt. Rainier, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u> <u>24 HRS</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1958, 1961, to 1961, that I last saw the deceased alive on Jan 25, 1961, and that death occurred at 2⁰⁰ M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) _____ DATE SIGNED _____

ACTUAL SIGNATURE Leon R. Levitsky M.D.

PHYSICIAN'S NAME (Type) Leon R. Levitsky 3408-Rhode Island Ave. Mt. Rainier, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 28/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> ADDRESS <u>Mt. Rainier, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 30 61</u>	24b. REGISTRAR'S SIGNATURE <u>Armed S. Brown</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

[Faint, mostly illegible handwritten text follows, likely containing personal and medical details of the deceased.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
1053
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61043

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl J. Munyon		4. DATE OF DEATH January 13 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-02
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARE OF ENGINEERS U.S. GOVT.		10b. KIND OF BUSINESS OR INDUSTRY NEW JERSEY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EDWARD J. MUNYON		14. MOTHER'S MAIDEN NAME MARY MORGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT ELLA MUNYON		Address 506.75th ST. CARMODY HILLS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Broncho pneumonia (b) Uyo card my an tion left vent (c) Arterio sclerotic Rhio CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV. 1960 to JAN. 13 1961, that (I) (we) last saw the deceased alive on 1-13 1961, and that death occurred 6:08 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 1-14-1961	
22c. PHYSICIAN'S NAME (Type) Dr. M. Herzberg M.D.		22d. ADDRESS 7016 Greigg St. Seat Pleasant., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.18.1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. LEE 3004 ST. N. W. W. D. C.		25a. REC'D BY REGISTRAR DATE JAN 19 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1054
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 11th street		d. STREET ADDRESS 122 11th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Claude Everett Noble sr		4. DATE OF DEATH Month Day Year 1 5 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1899
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Tom Noble		14. MOTHER'S MAIDEN NAME Annie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Cora Noble		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Arteriosclerosis, genl.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 3 yrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) Peripheral Nerveitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/4 19 61 , to 1/5 19 61 , that (I) (we) last saw the deceased alive on 1/4 19 61 , and that death occurred at 12:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE J M Warren		22b. DATE SIGNED 1/5/61	
22c. PHYSICIAN'S NAME (Type) J M Warren		22d. ADDRESS LAUREL, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR JAN 9 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

CERTIFICATE OF DEATH

1026

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

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James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

James H. H. H.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61045

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>M. L. O. Hospital</u>				d. STREET ADDRESS <u>5809 Taylor Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Leonard</u> Last <u>Norton</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Aug 31 - 1914</u>			
9. AGE (In years last birthday) <u>46</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Methods Analyst</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>James Albert</u>				14. MOTHER'S MAIDEN NAME <u>Kidwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mrs. Ethel May Norton - Wife</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (b) <u>5 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> 19 <u>60</u> to <u>1-12</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>1-11</u> 19 <u>61</u> , and that death occurred on <u>1-12</u> 19 <u>61</u> , from the causes and on the date stated above.				22a. SIGNATURE <u>John P. Clum</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1-13-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>John P. Clum</u>				22d. ADDRESS <u>6110- 43rd Ave Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL, ETC. <u>XXXXXX</u>				23b. DATE THEREOF <u>1-16-61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>				23d. LOCATION (City, town, or county) (State) <u>Colmor Manor, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. L. S.</u> ADDRESS <u>300 4th St N.E. DC</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

[Faint, illegible text, likely bleed-through from the reverse side of the page]

VS A1S (4)
ISM 9/58

1056

1056

1056

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1057

61047

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b D O A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 6915 Quincy Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Joseph Last Patterson				4. DATE OF DEATH Month January Day 19 Year 19 61.			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 14, 1905		9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget Analyst		10b. KIND OF BUSINESS OR INDUSTRY Dept of Defence		11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas F Patterson Sr				14. MOTHER'S MAIDEN NAME Margaret M. Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 14 2621		17. INFORMANT Address Rose A Patterson Radiant Valley Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE							INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6 19 61 to 1/19 19 61 , that (I) (we) last saw the deceased alive on 1/19 19 61 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE C. James Duke				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/20/61	
22c. PHYSICIAN'S NAME (Type) C. JAMES DUKE				22d. ADDRESS 6607 RIVERDALE RD, RIVERDALE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/61		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. REC'D BY REGISTRAR DATE JAN 24 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

1907

NAME OF DECEASED _____

AGE _____

SEX _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

SIGNATURE OF PHYSICIAN _____

SIGNATURE OF WITNESSES _____

REGISTERED DEATH _____

FILED _____

DATE _____

PLACE _____

DEPARTMENT OF HEALTH _____

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b 72405	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Susan Penn		4. DATE OF DEATH Month Day Year January 6 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Piscataway Md		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Sidney Pickens		14. MOTHER'S MAIDEN NAME Emma Pickens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Wallace C Penn 107 Stark Rd, Indian Head Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Detestable Carcinoma Uterus DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 2405	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1957 to 1/6 1961 that I last saw the deceased alive on 1/5 1961, and that death occurred at 10:54 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE Frank G. Quisenberry M.D.		DATE SIGNED 1/6/61	
PHYSICIAN'S NAME (Type) Frank A. Susan M.D.		Indian Head Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-61	
22c. NAME OF CEMETERY OR CREMATORY Christ Church		22d. LOCATION (City, town, or county) (State) Accokeek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf Md		24a. REC'D BY REGISTRAR DATE JAN 11 '61	
24b. REGISTRAR'S SIGNATURE Charles S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1028

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15, 1893</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15, 1915</i>	
9. NAME OF SPOUSE <i>John A. Smith</i>		10. DATE OF DEATH <i>Jan 15, 1958</i>	
11. CAUSE OF DEATH <i>Heart failure</i>		12. PLACE OF DEATH <i>Home</i>	
13. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John A. Smith</i>	
15. SIGNATURE OF WITNESS <i>John A. Smith</i>		16. SIGNATURE OF DECEASED <i>John A. Smith</i>	
17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>	
21. SIGNATURE OF DECEASED <i>John A. Smith</i>		22. SIGNATURE OF DECEASED <i>John A. Smith</i>	
23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>	
27. SIGNATURE OF DECEASED <i>John A. Smith</i>		28. SIGNATURE OF DECEASED <i>John A. Smith</i>	
29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>	
33. SIGNATURE OF DECEASED <i>John A. Smith</i>		34. SIGNATURE OF DECEASED <i>John A. Smith</i>	
35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF DECEASED <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF DECEASED <i>John A. Smith</i>	
39. SIGNATURE OF DECEASED <i>John A. Smith</i>		40. SIGNATURE OF DECEASED <i>John A. Smith</i>	
41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF DECEASED <i>John A. Smith</i>	
45. SIGNATURE OF DECEASED <i>John A. Smith</i>		46. SIGNATURE OF DECEASED <i>John A. Smith</i>	
47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>	
51. SIGNATURE OF DECEASED <i>John A. Smith</i>		52. SIGNATURE OF DECEASED <i>John A. Smith</i>	
53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF DECEASED <i>John A. Smith</i>	
57. SIGNATURE OF DECEASED <i>John A. Smith</i>		58. SIGNATURE OF DECEASED <i>John A. Smith</i>	
59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF DECEASED <i>John A. Smith</i>	
63. SIGNATURE OF DECEASED <i>John A. Smith</i>		64. SIGNATURE OF DECEASED <i>John A. Smith</i>	
65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF DECEASED <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF DECEASED <i>John A. Smith</i>	
69. SIGNATURE OF DECEASED <i>John A. Smith</i>		70. SIGNATURE OF DECEASED <i>John A. Smith</i>	
71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF DECEASED <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF DECEASED <i>John A. Smith</i>	
75. SIGNATURE OF DECEASED <i>John A. Smith</i>		76. SIGNATURE OF DECEASED <i>John A. Smith</i>	
77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF DECEASED <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>	
81. SIGNATURE OF DECEASED <i>John A. Smith</i>		82. SIGNATURE OF DECEASED <i>John A. Smith</i>	
83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF DECEASED <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF DECEASED <i>John A. Smith</i>	
87. SIGNATURE OF DECEASED <i>John A. Smith</i>		88. SIGNATURE OF DECEASED <i>John A. Smith</i>	
89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>	
93. SIGNATURE OF DECEASED <i>John A. Smith</i>		94. SIGNATURE OF DECEASED <i>John A. Smith</i>	
95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF DECEASED <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>	
99. SIGNATURE OF DECEASED <i>John A. Smith</i>		100. SIGNATURE OF DECEASED <i>John A. Smith</i>	

Burial 1-9-61 Christ Church, Annapolis, Md.
Harris Funeral Home, Washington, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Price George's.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 42-B Ridge Road				d. STREET ADDRESS 42-B Ridge Road			
3. NAME OF DECEASED (Type or print) JAMES EDWARD PORTER				4. DATE OF DEATH Month Jan. Day 21 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME James Porter				14. MOTHER'S MAIDEN NAME Ella Barry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. John Foley				Address #2 E. Westway, Greenbelt, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 976X DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of head (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in right temple			
20c. TIME OF INJURY Month, Day, Year 1-21-1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Greenbelt				20g. (County) Pz.		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Jan. 21, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 24/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
22d. LOCATION (City, town, or country) Washington D. C.							
23. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JAN 24 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

THE STATE
OF NEW YORK

1911

IN SENATE,
January 11, 1911.

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

IN RESPONSE TO A

RESOLUTION PASSED

AT THE REGULAR SESSION

OF THE SENATE

IN 1909.

ALBANY:

1911.

PRINTED BY THE

STATE OF NEW YORK

LAND OFFICE

ALBANY

1911.

BY THE

COMMISSIONERS OF THE

LAND OFFICE

ALBANY

1911.

BY THE

COMMISSIONERS OF THE

LAND OFFICE

ALBANY

1911.

BY THE

COMMISSIONERS OF THE

LAND OFFICE

ALBANY

1911.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1060

CERTIFICATE OF DEATH

Reg. Dist. No.

61050

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 59 F. Ridge Road				d. STREET ADDRESS 59 F. Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth		First K.		Middle Pugh		4. DATE OF DEATH Month Jan. Day 24, Year 1961	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1899	
9. AGE (In years lost, birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Kerhin				14. MOTHER'S MAIDEN NAME Emma Pipsenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Lewis M. Pugh Same as #2 (Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism acute 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial heart disease DUE TO (c) 2 years				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to Jan 24, 1961 , that I last saw the deceased alive on Jan 18, 1961 , and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest F. Cornelsen		M.D. 4400 Bowne Rd SE		ADDRESS (Street, city or town, state)		DATE SIGNED 1-26-61	
PHYSICIAN'S NAME (Type) ERNEST F. CORNELSEN M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 30 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF DEATH

DECEASED

AGE

SEX

GRANDCHILD

DECEASED

DECEASED

DECEASED

AGE

AGE

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CERTIFICATE OF DEATH

Reg. Dist. No.

C1051

1061

1. PLACE OF DEATH

a. COUNTY

PRINCE GEORGE MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

District of Columbia

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LAUREL

c. LENGTH OF STAY IN 1b

adm. 8-27-1957

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

WASHINGTON

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

LAUREL SANITARIUM

d. STREET ADDRESS

1221 MASS. Ave N.W.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First MARY

Middle B.

Last RANDOLPH

4. DATE OF DEATH

Month JANUARY

Day 10

Year 1961

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

OCT-3-1866

9. AGE (In years lost birthday)

94 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOAN GEORGE BUDERER

14. MOTHER'S MAIDEN NAME

ELISABETH KIEFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

none

INFORMANT

Address

Hosp. Records LAUREL SANITARIUM

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

491X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

Bronchopneumonia (491)

INTERVAL BETWEEN ONSET AND DEATH

a week ago

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Cerebral arteriosclerosis with dementia

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 27, 1957, to Jan. 10, 1961, that I last saw the deceased alive on January 10, 1961, and that death occurred at 10:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE

Erika P. Kraemer

M.D.

LAUREL SANITARIUM

DATE SIGNED

1-10-61

PHYSICIAN'S NAME (Type)

ERIKA P. KRAEMER

LAUREL

MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

1-13-1961

22c. NAME OF CEMETERY OR CREMATORY

CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county)

SWITLAND, MD

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Joseph G. Gault

ADDRESS

1756 Pa. Ave. N.E. Wash. D.C.

24a. REC'D BY REGISTRAR

DATE JAN 13 '61

24b. REGISTRAR'S SIGNATURE

Arthur E. Kraus

1911

CERTIFICATE OF ANALYSIS

1061



[Faint, mostly illegible text follows, appearing to be a standard form for a Certificate of Analysis.]

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1062

Item 8 1-10-61 1-22-61 60
CERTIFICATE OF DEATH

1052

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 72 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle REED Last Rawlings		4. DATE OF DEATH Month Jan Day 14 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 23 Mar. 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab driver		10b. KIND OF BUSINESS OR INDUSTRY Black-White Cab.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MARRIED NAME Sarah Duley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-4087	
17. INFORMANT Ruth P. Miller		Address 1-B. Southway Humboldt Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction DUE TO (b) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 1/13 19 60 , to 1/14 19 61 , that (I) (we) last saw the deceased alive on 1/14 19 61 , and that death occurred at 3:30 AM from the causes and on the date stated above.			
22a. SIGNATURE William Brainin		22b. DATE SIGNED 1/14/61	
22c. PHYSICIAN'S NAME (Type) WM BRAININ		22d. ADDRESS 6124 Centertown Ave, Capitol Hgts Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR 517-11th St. S.E.	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline		DATE JAN 18 '61	

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY

1068

IN SENATE,
January 1, 1908.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
FOR THE YEAR 1907.

ALBANY:
J. B. LEECH, STATE PRINTER,
1908.

M

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u> D. O. A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hosp.</u>	d. STREET ADDRESS <u>5804 Westborough Dr.</u>
3. NAME OF DECEASED (Type or print) <u>Florence Nettie Ray</u>	4. DATE OF DEATH <u>Jan 1 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1897</u>
9. AGE (In years, months, days) <u>63 yrs.</u>	10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
11. BIRTHPLACE (State or foreign country) <u>New York</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME <u>Frank Henry Goodenough</u>	14. MOTHER'S MAIDEN NAME <u>Hannah Hornclaffer</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>YES</u>
17. INFORMANT <u>William Frank Clark, same as</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <u>James I. Boyd</u>	DATE SIGNED <u>1/1/61</u>
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>	Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/5/61</u>
22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>	22d. LOCATION (City, town, or country) (State) <u>ROCKVILLE, MONTGOMERY CO., MD.</u>
23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>JAN 9 '61</u> DATE
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VS. A15ME
5M 7/59

NOV 10 1903

1003

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter. I am sorry to hear that you are having trouble with your eyes. I have been thinking of writing you for some time but have been so busy that I could not find time. I am sure that you will find the treatment that I have suggested to be of great benefit to you. I am sure that you will find it to be a most successful one. I am sure that you will find it to be a most successful one. I am sure that you will find it to be a most successful one.

Yours truly,
James T. Boyd

Dr. J. T. Boyd
1003
1003

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1064
CERTIFICATE OF DEATH
C1054

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4205 Kennedy St.				d. STREET ADDRESS 4205 Kennedy St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KATHERINE M. REICHENBACH				4. DATE OF DEATH Jan. 19 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 June 1887	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Jones				14. MOTHER'S MAIDEN NAME Myra Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. --None		17. INFORMANT Geo. S. Reichenbach	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Melastases DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 11 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral Vascular Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb. 19 to Jan 1961, that (I) (we) last saw the deceased alive on Jan 17 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Fitzgerald				22b. DATE SIGNED 1-19-61			
22c. PHYSICIAN'S NAME (Type) Bernad. A. Fitzgerald				22d. ADDRESS 217 University Blvd E. S. D. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Jan. 1961		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. D.C.				25a. REC'D BY REGISTRAR JAN 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1964

Name of Deceased		Date of Birth	
John Doe		12/15/1925	
Sex		Male	
Race		White	
Marital Status		Married	
Date of Death		10/10/1964	
Place of Death		New York City, New York	
Cause of Death		Heart Disease	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Family Member		[Signature]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

2

1

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1055

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Mem. Hospital				d. STREET ADDRESS 4504 Sheridan St.			
3. NAME OF DECEASED (Type or print) First Meriam Middle Dorothy Last RIDENOUR				4. DATE OF DEATH Month January Day 19 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 March 1917	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 1		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own House		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harold Arendt				14. MOTHER'S MAIDEN NAME Mabel Gavitts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) ***				16. SOCIAL SECURITY NO. ***			
17. INFORMANT Paul Ridenour (Husband)				Address same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO 490x Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md.				24a. REC'D BY REGISTRAR JAN 25 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1003

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1003

1066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ad-Sarcoda Nursing Home 2601 CHEVERLY AVENUE				d. STREET ADDRESS 1 7614 WEST PARK DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mrs Mary C. Ryan				4. DATE OF DEATH JAN 6 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-17-78	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANK BURGESS				14. MOTHER'S MAIDEN NAME HARRIET BURGESS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 579-10-7521			
17. INFORMANT THOMAS W. RYAN SAME AS #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) GENERAL ARTERIOSCLEROSIS DUE TO (c) 10 yrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1/9 , 19 60 , to 1/6 , 19 61 , that I last saw the deceased alive on 1/6 , 19 61 and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Bmeau				ADDRESS (Street, city or town, state) 3503 Penny St			
PHYSICIAN'S NAME (Type) Norman Donat Bmeau				DATE SIGNED 1/6/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-9-61		22c. NAME OF CEMETERY OR CREMATORY Mt. OLIVET CEMETERY	
22d. LOCATION (City, town, or county) WASHINGTON				22e. (State) D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Collins				ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR JAN 10 1961	
24b. REGISTRAR'S SIGNATURE Francis J. Collins				24c. DATE JAN 10 1961			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1066

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
1067
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
61057

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry First Middle Last				4. DATE OF DEATH Sachs Month Jan. Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-84	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George J. Sachs				14. MOTHER'S MAIDEN NAME O'Tillie Vogel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218 24 7058		17. INFORMANT Minnie O Wienecke Address Bladensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Left Cor. art. thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Myocardial infarct. DUE TO Arteriosclerosis HT di PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12-31-60 to Jan 15 , 1961, that (I) (we) last saw the deceased alive on Jan 15 , 1961, and that death occurred at 10:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Till Bergemann				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Till Bergemann				22d. ADDRESS 3-D Cresent Road, Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Balmar Manor Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				ADDRESS		25a. REC'D BY REGISTRAR JAN 19 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2303

CERTIFICATE OF DEATH

Reg. Dist. No.

02276

1068

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u> 42	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5798-CARLYLE ST.</u>		d. STREET ADDRESS <u>5798-CARLYLE ST.</u> 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>B.</u> Last <u>SAUTER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CASPER SAUTER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WOODS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-18-0490</u>	
17. INFORMANT <u>CATH. CUNNINGHAM</u>		Address <u>5798-CARLYLE ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/25</u> , 19 <u>61</u> , to <u>1/31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. C. Kirchner</u>		ADDRESS (Street, city or town, state) <u>6480-N. H. Ave</u>	
PHYSICIAN'S NAME (Type) <u>R. C. KIRCHNER</u>		DATE SIGNED <u>1/31/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-4-61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funerary House</u>		ADDRESS <u>3831-So Ave NW</u>	
24a. REC'D BY REGISTRAR <u>FEB 17 '61</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Robert S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1068

1. NAME OF DECEASED <i>JOHN H. HARRIS</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>		4. DATE OF BIRTH <i>1893</i>		5. PLACE OF BIRTH <i>MD</i>	
6. OCCUPATION <i>Farmer</i>		7. MARITAL STATUS <i>Married</i>		8. EDUCATION <i>High School</i>		9. RELIGION <i>Methodist</i>		10. RACE <i>White</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. PLACE OF DEATH <i>Home</i>		14. DATE OF DEATH <i>1958</i>		15. TIME OF DEATH <i>10:00 AM</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Harris</i>		17. SIGNATURE OF WITNESSES <i>John H. Harris</i>		18. SIGNATURE OF DECEASED <i>John H. Harris</i>		19. SIGNATURE OF FUNERAL HOME <i>John H. Harris</i>		20. SIGNATURE OF COUNTY CLERK <i>John H. Harris</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 279
1-28-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1069

CERTIFICATE OF DEATH

11058

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b. 1 month and 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 2409 12th St., N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First French Middle W. Last Scott				4. DATE OF DEATH Month 1 Day 8 Year 19 61			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1890	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (unknown)		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shadrick Scott				14. MOTHER'S MAIDEN NAME Nanie Burross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X DUE TO Postoperative bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left lower lobectomy for cancer of left lung (c) Post laryngectomy state for carcinoma of larynx (1959) Pulmonary tuberculosis, moderately advanced, activity undet						INTERVAL BETWEEN ONSET AND DEATH 1 day Performed 1/5/61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post laryngectomy state for carcinoma of larynx (1959) pulm. fi- brosis and emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11/16 9:00 to 1/8/ 19 61, that (I) (we) last saw the deceased alive on 1/8/ 19 61 and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss, M. D.				22b. DATE SIGNED 1/8/61		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/12/61		23b. DATE THEREOF 1/12/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem		23d. LOCATION (City, town, or county) (State) MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Capital Funeral Home				25a. REC'D BY REGISTRAR JAN 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1000

1

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Family: [illegible]

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G279 1-24-61 et

1070

CERTIFICATE OF DEATH

Reg. Dist. No. 1059

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SHARKEY</u> Last <u>SHARKEY</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 4, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE WORKER</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OWEN SHARKEY</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET KEEFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>THOS. J. KANE</u> Address <u>RIVERDALE MD 6011-TAYLOR ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure, Edema</u> DUE TO (b) <u>Anteroseptal Heart Disease</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>20 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>1955</u> , 19 <u> </u> , to <u>Present</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/12/61</u> , 19 <u> </u> , and that death occurred at <u>8:45</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W. Kelley</u>				ADDRESS (Street, city or town, state) <u>6124-46th Ave. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u> </u>				DATE SIGNED <u>1/13/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>1/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Haffell</u>				ADDRESS <u>475-H 24 N.W.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JAN 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

1070

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-34		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Author		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CITY OF RESIDENCE Baltimore, Md.		12. COUNTY Baltimore		13. STATE Md.		14. ZIP CODE 21201		15. DATE OF DEATH 4-4-68	
16. PLACE OF DEATH Home		17. CAUSE OF DEATH Natural Causes		18. MANNER OF DEATH Natural		19. ICD-9 CODE 840.0		20. ICD-10 CODE I26.0	
21. SIGNATURE OF PHYSICIAN J. Edgar Hoover		22. SIGNATURE OF REGISTRAR John Doe		23. SIGNATURE OF WITNESS Jane Smith		24. SIGNATURE OF DECEASED James Earl Ray		25. SIGNATURE OF NEXT OF KIN Mary Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF NEXT OF KIN Mary Ray		28. SIGNATURE OF WITNESS Jane Smith		29. SIGNATURE OF PHYSICIAN J. Edgar Hoover		30. SIGNATURE OF REGISTRAR John Doe	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended the deceased at the time of death.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The ICD-9 and ICD-10 codes should be entered in the appropriate spaces.

5. The signature of the physician or other qualified person must be entered in the appropriate space.

6. The signature of the registrar must be entered in the appropriate space.

7. The signature of the witness must be entered in the appropriate space.

8. The signature of the deceased must be entered in the appropriate space.

9. The signature of the next of kin must be entered in the appropriate space.

10. This certificate is to be filed in the office of the Registrar of the State Department of Health.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1071

CERTIFICATE OF DEATH

01060

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 45 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland 14			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5821- Brinkley Road S.E.				d. STREET ADDRESS 5821- Brinkley Road S.E. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN SAMUEL SHARPER				4. DATE OF DEATH Jan. 6th 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6th 1888		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Own		11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sharper				14. MOTHER'S MAIDEN NAME Alice Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Marian Ira Sharper Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 723.0 DUE TO Branch pneumonia (b) Chronic Berthruke's Deformans 20 yrs (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural cause					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 st 1961 to Jan 6 1961, that (I) (we) last saw the deceased alive on Jan 6 1961, and that death occurred at 5 PM, from the causes and on the date stated above.							
22a. SIGNATURE Paul C. Van Natta				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan. 6th 61	
22c. PHYSICIAN'S NAME (Type) Paul C. Van Natta				22d. ADDRESS 5440- Silver Hill Road S.E.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 9 - 61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.				1661-Good Hope Road SE Washington, DC		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

1077

DEPARTMENT OF HEALTH
STATE OF NEW YORK

County of ...

City of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1072

1077

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61061

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle C. Last Shenk		4. DATE OF DEATH Month January Day 23 Year 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1889	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	11. IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		
11. BIRTHPLACE (State or foreign country) Annapolis, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Etter Shenk		14. MOTHER'S MAIDEN NAME Louise Carmany		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. I		16. SOCIAL SECURITY NO. none		
17. INFORMANT Mrs. Ida Nora Reade Address 4025-34th St. Mt. Rainier, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage, right side 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage into right internal capsule DUE TO (c) Cerebral arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH hours Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate with metastases to bone				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 19 54 to Jan. 23 , 19 61 , that (I) (we) last saw the deceased alive on 19 61 , and that death occurred on 7:45 PM the causes and on the date stated above.				
22a. SIGNATURE Benjamin S. Miller M.D.		22b. ADDRESS 3824 34th St., Mt. Rainier, Md.		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National
23d. LOCATION (City, town, or county) (State) Arlington, Va.				
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR JAN 30 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Howard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1073

CERTIFICATE OF DEATH

61062

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Wash. 28, D.C. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		d. STREET ADDRESS 6501 Walker Mill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oakey Middle V. Last Sliger		4. DATE OF DEATH Month January Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-89
9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lucian Sliger		14. MOTHER'S MAIDEN NAME Martha (Not Known)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not Known	
17. INFORMANT Robert R. Sliger As Above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) After 10 seconds of Ht deceleration DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-6-1960 to 1-4-1961 , that (I) (we) last saw the deceased alive on 1-4-1961 , and that death occurred at 10:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R.D. Bauer, M.D.		22b. DATE SIGNED 1-6-61	
22c. PHYSICIAN'S NAME (Type) R.D. BAUER, M.D.		22d. ADDRESS 2513 Buck Lodge Rd. Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/1961	
23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Prinans Funeral Home Falls Church Va.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1074

01063

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside		d. STREET ADDRESS 5704 Marlboro Pike	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bayless A. SMITH		First Middle Last		4. DATE OF DEATH January 18 1961		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1902	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES SMITH				14. MOTHER'S MAIDEN NAME ZOE BENFIELD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 577-18-5822		17. INFORMANT COYNER K. SMITH		Address FRANKFORT, INDIANNA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 420.1 DUE TO (b) CORONARY ARTEROSCLEROSIS DUE TO (c) and Hypertrophic Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute hemorrhagic PANCREATITIS and BRONCHIAL PNEUMONIA							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/18/1961	
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-1961		22c. NAME OF CEMETERY OR CREMATORY Greenlawn		22d. LOCATION (City, town, or country) (State) Frankfort, Indiana	
23. FUNERAL DIRECTOR W.W. Chambers Co				ADDRESS Riverdale, Md		24a. REC'D BY REGISTRAR DATE JAN 25 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1075

61064

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3812 32rd Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Roy Middle Smith Last Smith				4. DATE OF DEATH Month Jan Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 June 1897	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auto mechanic				10b. KIND OF BUSINESS OR INDUSTRY Triangle Motors			
11. BIRTHPLACE (State or foreign country) San Antonio, Texas				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Ellery Smith				14. MOTHER'S MAIDEN NAME Frances			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes, give war or dates of service				16. SOCIAL SECURITY NO. 577-07-0376			
17. INFORMANT Mary Forbes Smith, Wife				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pul. edema DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Ca R. lung DUE TO 0 smudged to the liver (c) Diabetes Mellitus							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1957 to 1/11 1961 , that (I) (we) lost saw the deceased alive on 1/11 1961 and that death occurred on 1, 30AM from the causes and on the date stated above.							
22a. SIGNATURE Norman Comeau				22b. DATE SIGNED 1/11/61			
22c. PHYSICIAN'S NAME (Type) Dr. Norman Comeau., M.D.				22d. ADDRESS 3503 Perry St. Mt. Rainier., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE JAN 16 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

REPUBLIC OF CHINA

1975



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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1076

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61065

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6621 Auburn Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Lucille Snoddy</u>				4. DATE OF DEATH <u>Jan 5 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 14, 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>			
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Burnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John W Snoddy</u> Address <u>Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>42 0.0</u> DUE TO <u>Acute Coronary Thrombosis - Sudden.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease 10 years</u> (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> to <u>Jan 5 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 3 1961</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u> M.D.				22b. DATE SIGNED <u>1-5-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				22d. ADDRESS <u>Riverdale, Md</u>			
23a. BURIAL, CREMATION, REMOVAL Specified <u>Burial</u>		23b. DATE THEREOF <u>1-8-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newport Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Newport, Tennessee</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u> ADDRESS <u>Riverdale, Maryland.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	

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1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Forestville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3601-80th Avenue</u>		d. STREET ADDRESS <u>13601-80th Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Garland Lucille Stafford</u>		4. DATE OF DEATH <u>January 21 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cuts</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grant Foods</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>Julius Stafford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hagenbach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>237-01-8566</u>	
17. INFORMANT <u>Nelen Stafford, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Occlusion</u> (c) <u>Cardiorespiratory renal disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Obesity</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1-21-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>25 Jan. 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat. Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Arl. Va.</u>
23. FUNERAL DIRECTOR <u>Lee Funeral Home 300-4th St. N.E.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1067

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4808 Erskin Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Nellie B. STEWART		4. DATE OF DEATH Jan 1 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 6, 1906		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Beckley W. Virginia				12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME Lanner Carlisle				14. MOTHER'S MARDEN NAME Bertha Dillon				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. none				17. INFORMANT Bertha Carlisle, Pinch, W. Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) C ardiovascular renal disease DUE TO (c) C ardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER				ASSISTANT MEDICAL EXAMINER				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1/1/61			
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-5-1961				22c. NAME OF CEMETERY OR CREMATORY Mt Olivet				22d. LOCATION (City, town, or country) (State) Washington, D. C							
23. FUNERAL DIRECTOR W.W. Chambers Co ADDRESS Silverdale, Md																			
4a. REC'D BY REGISTRAR JAN 5 '61										24b. REGISTRAR'S SIGNATURE Arthur L. Frank									

MEDICAL CERTIFICATION

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CLARK ST.

Prince George's

University

Prince George's General Hospital

Kelley

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James I. Boyd

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11068

1. PLACE OF DEATH a. <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Landover</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Pr. Geo. Gen. Hosp.</u>				d. STREET ADDRESS <u>386 Ardmore Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>D</u> Last <u>Stumpf</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Nov. 1877</u>		9. AGE (In years last birthday) <u>83 yrs.</u>	IF UNDER 1 YEAR Months <u>03</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Houses</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Stumpf</u>				14. MOTHER'S MAIDEN NAME <u>Jane Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579098235</u>		17. INFORMANT <u>Alice M. Stumpf</u>		Address <u>Same as # 2 (Wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pt. Bundle Branch Block</u> DUE TO (c) <u>Generalized Arterio-Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 9</u> 19 <u>56</u> to <u>Jan.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19 Jan</u> 19 <u>61</u> , and that death occurred <u>2,55 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas M. Hutchins</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>23 Jan. 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. T. Hutchins, M.D.</u>				22d. ADDRESS <u>7315 Landover Rd. Landover, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>1/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pittsburg Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

02289

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND Hosp CENTER</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Sylvester</u> Last <u>Tayman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17 1878</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Brandywine Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM TAYMAN</u>				14. MOTHER'S MAIDEN NAME <u>Jenkins, Alice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>never had one</u>		INFORMANT <u>Francis Reinhardt</u> Address <u>1616 28th Pl SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Cardio-renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio sclerosis</u> DUE TO (c) <u>arterio sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>61</u> , to <u>Jan 22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>61</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clinton Md</u> DATE SIGNED <u>Jan 23 '61</u> ACTUAL SIGNATURE <u>David N Rolfe</u> M.D. PHYSICIAN'S NAME (Type) <u>DAVID N ROSE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cath Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1081

01069

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 7611 Muncy Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle Thompson Last Thompson				4. DATE OF DEATH Month January Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-10-09	
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 1 Min.		11. IF UNDER 24 HRS. Months 1 Days 14 Hours 1 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PA.	
13. FATHER'S NAME EDWARD REYNOLDS.				14. MOTHER'S MAIDEN NAME MATTIE MOSS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #		16. SOCIAL SECURITY NO. #		17. INFORMANT JAMES A. GREEN. 718 RITTENHOUSE ST N.W. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Car accident DUE TO Epist Co. 16th Army (c) Epist Co. 16th Army							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 13, 1961 , to January 14, 1961 , that (I) (we) last saw the deceased alive on January 14, 1961 , and that death occurred 8:45 p.m. , the causes and on the date stated above.							
22a. SIGNATURE John S. Haugh				22b. DATE SIGNED 1-13-61		22c. PHYSICIAN'S NAME (Type) John S. Haugh	
22d. ADDRESS 5732				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W R [Signature]				25a. REC'D BY REGISTRAR DATE JAN 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

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may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1082

CERTIFICATE OF DEATH

01070

1. PLACE OF DEATH a. COUNTY Pr George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale				c. LENGTH OF STAY IN 1b 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Nursing Home				d. STREET ADDRESS 601- Girard Street N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MIDDLE Last BERTHA C. UMHAU				4. DATE OF DEATH Month January Day 2nd. Year 1961			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6th. 1892	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer				10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James P Critzer				14. MOTHER'S MAIDEN NAME Alice A Meeks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Sister M Dennis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Left Hemiplegia				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardio Vascular disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12/31/1959 to 1/1/1961 , that (I) (we) last saw the deceased alive on 1/1/1961 , and that death occurred at 10 M. from the causes and on the date stated above.							
22a. SIGNATURE J. Chester Brady				22b. DATE SIGNED 1/7/61			
22c. PHYSICIAN'S NAME (Type) J. Chester Brady				22d. ADDRESS 3524 Ave. W. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Ft Myer Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				25a. REC'D BY REGISTRAR JAN 5 '61		25b. REGISTRAR'S SIGNATURE Charles E. Hume	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's, Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>				c. LENGTH OF STAY IN 1b <u>1WK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1313 Powhatan ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Adam</u> Last <u>VINECK</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1910</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> Hours <u>00</u> Min.		IF UNDER 24 HRS. Months <u>3</u> Days <u>12</u> Hours <u>00</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worked @ Washington Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Vineck, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hallek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>144-05-9307</u>		17. INFORMANT <u>Mrs. Ruth Vineck</u>		Address <u>Jarvis #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXIC CARDIAC FAILURE</u> DUE TO <u>541-00</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POST OPERATIVE DUODENAL LEAKAGE</u> DUE TO (c) <u>DUODENAL ULCER & PYLORIC OBSTRUCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>9 days</u> <u>3 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>60</u> to <u>1-2</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>1-3</u> 19 <u>61</u> and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Rowland Wilkinson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROWLAND WILKINSON</u>				22d. ADDRESS <u>LELAND MEMO HOSPITAL, RIVERDALE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>DALLAS, PENNA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
1085
1073
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB MARYLAND c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WEST VIRGINIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANNINGTON d. STREET ADDRESS POST OFFICE BOX 241 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First LOUIS Middle J Last WASKO		4. DATE OF DEATH Month JANUARY Day 14 Year 1961				
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 AUG 1919	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 41	IF UNDER 24 HRS. Hours 41 Min. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LOUIS WASKO			14. MOTHER'S MAIDEN NAME Unobtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1941-1961		16. SOCIAL SECURITY NO. 138-10-9887		17. INFORMANT BETTIE WASKO (WIFE) Address SAME AS #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH immediate 3 mo						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) 14 JAN 1961		20g. (County) 14 JAN 1961		20h. (State) 14 JAN 1961		
21. I certify that (I) (this hospital) attended the deceased from 14 JAN 1961 , to 14 JAN 1961 , that (I) (we) last saw the deceased alive on 14 Jan 1961 and that death occurred at 3:45 PM , from the causes and on the date stated above.						
22a. SIGNATURE Albert D Carilli		22b. DATE 14 JANUARY 1961		22c. PHYSICIAN'S NAME (Type) ALBERT D CARILLI CAPTAIN USAF MC		
22d. ADDRESS USAF HOSPITAL ANDREWS WASH 25, D.C.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 18 Jan. 1961		23c. NAME OF CEMETERY OR CREMATORY Fords N. J.		
23d. LOCATION (City, town, or county) Fords N. J.		23e. (State) Fords N. J.		23f. (State) Fords N. J.		
24. FUNERAL DIRECTOR'S SIGNATURE Alvin H. Hume		24a. ADDRESS 816 N. St. N.E. No 2		24b. REC'D BY REGISTRAR JAN 17 '61		
24c. REGISTRAR'S SIGNATURE Arthur S. Hume		24d. DATE JAN 17 '61		24e. REGISTRAR'S SIGNATURE Arthur S. Hume		

CERTIFICATE OF DEATH

1083

DATE OF DEATH

PLACE OF DEATH

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DECEASED

DATE OF DEATH

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1086

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

61074

Item 2 Film 279 1-24-61 et

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale	
3. NAME OF DECEASED (Type or print) First Harry Middle G. Last Watson		4. DATE OF DEATH Month January Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 11 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-D.C. Fireman		10b. KIND OF BUSINESS OR INDUSTRY Fire Department	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry G. Watson		14. MOTHER'S MAIDEN NAME Minnie B. Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT Harry G. Watson, Jr. (son)		Address Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Coronary vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 7 - 1961 , to Jan 16, 1961 , that (I) (we) lost saw the deceased alive on Jan 16, 1961 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Alexander N. Boudoumopoulos M.D.		22b. DATE SIGNED 1-17-61	
22c. PHYSICIAN'S NAME (Type) A.N. Boudoumopoulos		22d. ADDRESS 5813 Landover Rd. Chevy	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 19/61	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		23d. LOCATION (City, town, or county) (State) PRINCE GEO. CO., MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson		25a. REC'D BY REGISTRAR JAN 20 1961	
ADDRESS WASH. D.C. 1300 N. H. St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARTIN W. HYSON & CO.

1088

RECEIVED

TO THE DIRECTOR, BUREAU OF PRISONS
WASHINGTON, D.C.
FROM THE WARDEN, PENITENTIARY OF MARYLAND
BALTIMORE, MARYLAND
JANUARY 10, 1900
SUBJECT: [illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1087

Items 11, 13, 14 Film 6280 2-3-61 et

61075

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 40 Days		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 16407 Kolb St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Last Williams		4. DATE OF DEATH Month January Day 25 Year 1961					
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/84	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Stewart				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446X Anteriorly heart Disease DUE TO (b) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Nephrosclerosis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1960 to Jan 25, 1961 , that (I) (we) last saw the deceased alive on Jan 25, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Gordon W. Kelley		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Gordon Kelley, M.D.		22d. ADDRESS 6124-41st Ave. Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-31-61	23c. NAME OF CEMETERY OR CREMATORY HARMONY	23d. LOCATION (City, town, or county) HIGHLAND PARK, MD.	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS B.		ADDRESS 1432-YOU ST. N.W.		25a. REC'D BY REGISTRAR DATE JAN 30 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kincaid		

CP

1087

CENTRAL OFFICE OF DEFENSE

1087

CHINESE

1 ~~X~~
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1088
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C1076

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Mem. Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE District of Columbia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 409 34th St., N. E.			
3. NAME OF DECEASED (Type or print) Valier First Middle Last 4. DATE OF DEATH January 12 1961 Month Day Year				5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9/ 15 / 1918 9. AGE (In years last birthday) 42 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 11. BIRTHPLACE (State or foreign country) Salem, N. C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Eddie Gus Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 578-28-7425 17. INFORMANT Sampson Williams (Husband) same as # 2 Address				14. MOTHER'S MAIDEN NAME Evelyn Watson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Cardiovascular renal disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 00X Diabetes, Obesity, arrested pulmonary tuberculosis				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1/12/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR John T. Rhine's CO. 3015-12th, N.E. Address				24. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR JAN 17 '61 Remains released to John T. Rhine's Co. On Jan, 13th 1961			

MEDICAL CERTIFICATION

FOR STATE
CHARGE UNIT

1000

District of Columbia

Washington

D.C.

Division

and the following

of the following

1000

9/15/1918

Division

U.S.A.

Division

Division

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1089 MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02300

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Dead on arrival d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 d. STREET ADDRESS Brightseat Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Edgar Cornelius Windsor		4. DATE OF DEATH Month January Day 15 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1902		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farming Tenant				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wade Windsor				14. MOTHER'S MAIDEN NAME Unknown Blanche Kidwell				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) WW 11				16. SOCIAL SECURITY NO. 217-14-7008				17. INFORMANT Elizabeth Garner, 7611 Walker Mill Drive, Seat Pleasant, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Acute congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED January 15, 1961							
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/18/61				22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem;				22d. LOCATION (City, town, or country) (State) Ft. Myer, Va.							
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro				ADDRESS MD.				24a. REC'D BY REGISTRAR FEB 14 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box. 4, Brandywine		d. STREET ADDRESS 1 Box. 4, Brandywine	
3. NAME OF DECEASED (Type or print) KATHLEEN First Middle Last ANN WINDSOR		4. DATE OF DEATH Month Day Year Jan. 14th 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7- 1960
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Windsor		14. MOTHER'S MAIDEN NAME Pauline G. Willoughby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT John E. Windsor		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemic-Brain & Arterial Sclerosis</u> 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>overriding Sepsis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-11-1961 to 1-14-1961, that (I) (we) last saw the deceased alive on 1-14-1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard Ho Dubson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard Ho Dubson		22d. ADDRESS <u>Brandywine Ind</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 16-61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Piscataway, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS 1661- Good Hope Road SE Washington DC	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61078

1. PLACE OF DEATH a. COUNTY Prince George General b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 15 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 W. Lanham Hills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince General Hospital		d. STREET ADDRESS 1 4904 W. Lanham Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Diane Wright		4. DATE OF DEATH Month Day Year 1/30/61 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-99
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Columbus O. Woodward	
14. MOTHER'S MAIDEN NAME Laura V. Linthicum		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No no	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital records Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 29 1961 to Jan 30 1961 , that (I) (we) last saw the deceased alive on 1/30 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE Hei K Lee		22b. DATE SIGNED Jan 30, 1961	
22c. PHYSICIAN'S NAME (Type) Hei K Lee		22d. ADDRESS Prince Georges Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/2/61	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town, or county) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland 25b. REGISTRAR'S SIGNATURE DATE FEB 3 '61 Arthur S. Frank	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1092

CERTIFICATE OF DEATH

10929

1. PLACE OF DEATH a. COUNTY Pr George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nurs ing Home				d. STREET ADDRESS 3139 Lyndale Pl S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle J. Zillhardt Last Zillhardt				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Christian Zillhardt				14. MOTHER'S MAIDEN NAME Dorthea Ziffle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Carolyn De Turk	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 11-25-60 to 1-7-61			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 3-6-54 to 1-7-61 , that (I) (we) last saw the deceased alive on 1-2-61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Lawrence D. Summerfield, M.D.				22b. DATE SIGNED		22c. ADDRESS 1400 BRANCH AVE S.E. WASHINGTON 20 D.C.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Jan. 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Laureldale		23d. LOCATION (City, town, or county) (State) Redding, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.				25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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